

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 6001

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Mary V. Koffenberger*

2. DATE OF DEATH

*7/7/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE *Md* B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*Nursing Home 2305 St. Paul St*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Balto.*

D. STREET ADDRESS (If rural, give location)

*2225 Homewood Ave*

C. Length of stay in Baltimore

*1 yr*

Yrs.  
Mos.  
Days

5. SEX  
*F.*

6. COLOR OR RACE  
*W.*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Widow*

8. DATE OF BIRTH

*Aug. 11, 1867*

9. AGE (In years last birthday)

*82*

If Under 1 Year Months: Days  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*None*

10B. KIND OF BUSINESS OR INDUSTRY

*None*

11. BIRTHPLACE (State or foreign country)

*Md*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Gordon*

14. MOTHER'S MAIDEN NAME

*—*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mrs. Dorothy Barry, 402 Lyndell*

18. *4771*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*arteriosclerosis  
Cardiovascular disease*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *May 25*, 19*50*, to *July 7*, 19*50*, that I last saw the deceased alive on *May 25*, 19*50*, and that death occurred at *7 A.* m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Jack J. Singer*

M. D.

*5062 North Ave*

*7/8/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Burial*

*7/10/50*

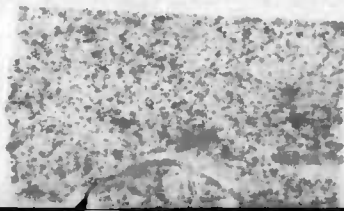
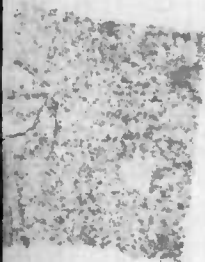
*New Catholic*

*Balto. Md*

*JUL 8 - 1950*

*William Williams*

*Harvey H. Wight, 4101 Edmondson*





160  
50 6002  
BIRTH NO.

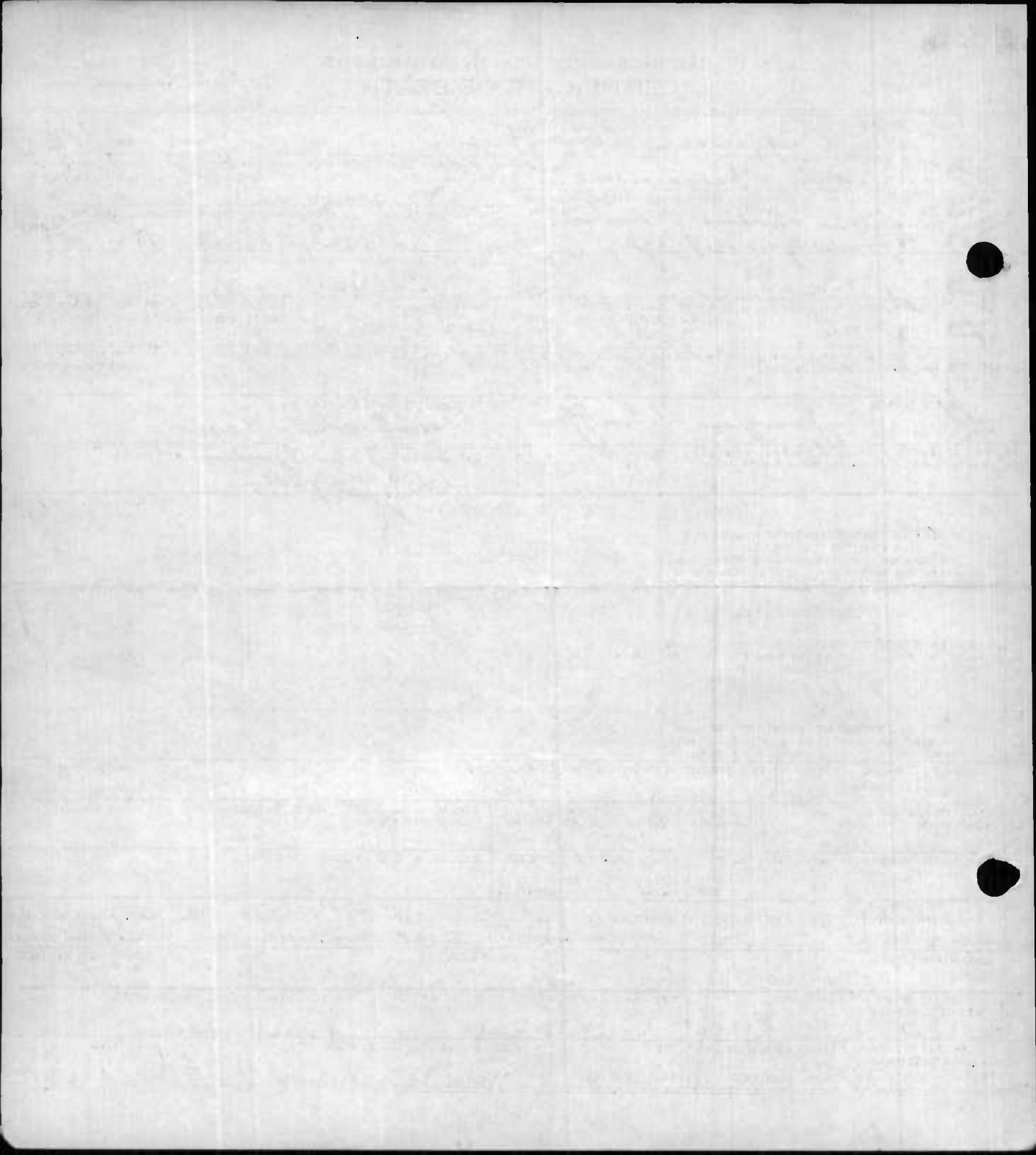
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6002  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Catherine Schaffer</i>		2. DATE OF DEATH <i>July 6 / 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Little Sisters of the Poor Home for the Aged</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1200 Valley St.</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>	8. DATE OF BIRTH <i>Aug. 6, 1870</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Joseph Schaffer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Nann</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Linda Symonakis</i>		ADDRESS <i>1200 Valley St.</i>	

1B. <i>421.4</i>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <i>Valvular Heart disease</i>	
ANTECEDENT CAUSES		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Nephritis</i>	
II		DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan.</i> , 19 <i>50</i> , to <i>July 6</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 5</i> , 19 <i>50</i> , and that death occurred at <i>5:20 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Jacob Fisher</i>		23B. ADDRESS <i>1823 N. West St.</i>		23C. DATE SIGNED <i>7/7/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 8, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Baltimore</i>		24E. FUNERAL DIRECTOR <i>Rita Wiedefeld</i>		24F. ADDRESS <i>900 E. Biddle St</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 8 - 1950</i>		REGISTRAR'S SIGNATURE <i>Amington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Rita Wiedefeld</i>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6003  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>William Cordrey</b>				2. DATE OF DEATH <b>July 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>3045 Brighton St.,</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>43--</b> Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <b>3045 Brighton St.,</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12/19/1871</b>	9. AGE (In years, last birthday) <b>78</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Not Known</b>		
14. MOTHER'S MAIDEN NAME <b>Not Known</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Mrs. Olivia E. Cordrey 3045 Brighton</b>		
18. <b>331X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebro-Vascular Accident</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerosis</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/5</b> 19 <b>50</b> , to <b>7/7</b> 19 <b>50</b> , that I last saw the deceased alive on <b>7/6</b> 19 <b>50</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>L. Enright Green</b>		23B. ADDRESS <b>Md. B to Redg</b>		23C. DATE SIGNED <b>7/8/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-10-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>G. Howard Strong 3207 W. North Ave.,</b>			

Prof. Einm. <sup>11</sup> ~~12~~ <sup>13</sup> ~~14~~ <sup>15</sup> ~~16~~ <sup>17</sup> ~~18~~ <sup>19</sup> ~~20~~ <sup>21</sup> ~~22~~ <sup>23</sup> ~~24~~ <sup>25</sup> ~~26~~ <sup>27</sup> ~~28~~ <sup>29</sup> ~~30~~ <sup>31</sup> ~~32~~ <sup>33</sup> ~~34~~ <sup>35</sup> ~~36~~ <sup>37</sup> ~~38~~ <sup>39</sup> ~~40~~ <sup>41</sup> ~~42~~ <sup>43</sup> ~~44~~ <sup>45</sup> ~~46~~ <sup>47</sup> ~~48~~ <sup>49</sup> ~~50~~ <sup>51</sup> ~~52~~ <sup>53</sup> ~~54~~ <sup>55</sup> ~~56~~ <sup>57</sup> ~~58~~ <sup>59</sup> ~~60~~ <sup>61</sup> ~~62~~ <sup>63</sup> ~~64~~ <sup>65</sup> ~~66~~ <sup>67</sup> ~~68~~ <sup>69</sup> ~~70~~ <sup>71</sup> ~~72~~ <sup>73</sup> ~~74~~ <sup>75</sup> ~~76~~ <sup>77</sup> ~~78~~ <sup>79</sup> ~~80~~ <sup>81</sup> ~~82~~ <sup>83</sup> ~~84~~ <sup>85</sup> ~~86~~ <sup>87</sup> ~~88~~ <sup>89</sup> ~~90~~ <sup>91</sup> ~~92~~ <sup>93</sup> ~~94~~ <sup>95</sup> ~~96~~ <sup>97</sup> ~~98~~ <sup>99</sup> ~~100~~ <sup>101</sup> ~~102~~ <sup>103</sup> ~~104~~ <sup>105</sup> ~~106~~ <sup>107</sup> ~~108~~ <sup>109</sup> ~~110~~ <sup>111</sup> ~~112~~ <sup>113</sup> ~~114~~ <sup>115</sup> ~~116~~ <sup>117</sup> ~~118~~ <sup>119</sup> ~~120~~ <sup>121</sup> ~~122~~ <sup>123</sup> ~~124~~ <sup>125</sup> ~~126~~ <sup>127</sup> ~~128~~ <sup>129</sup> ~~130~~ <sup>131</sup> ~~132~~ <sup>133</sup> ~~134~~ <sup>135</sup> ~~136~~ <sup>137</sup> ~~138~~ <sup>139</sup> ~~140~~ <sup>141</sup> ~~142~~ <sup>143</sup> ~~144~~ <sup>145</sup> ~~146~~ <sup>147</sup> ~~148~~ <sup>149</sup> ~~150~~ <sup>151</sup> ~~152~~ <sup>153</sup> ~~154~~ <sup>155</sup> ~~156~~ <sup>157</sup> ~~158~~ <sup>159</sup> ~~160~~ <sup>161</sup> ~~162~~ <sup>163</sup> ~~164~~ <sup>165</sup> ~~166~~ <sup>167</sup> ~~168~~ <sup>169</sup> ~~170~~ <sup>171</sup> ~~172~~ <sup>173</sup> ~~174~~ <sup>175</sup> ~~176~~ <sup>177</sup> ~~178~~ <sup>179</sup> ~~180~~ <sup>181</sup> ~~182~~ <sup>183</sup> ~~184~~ <sup>185</sup> ~~186~~ <sup>187</sup> ~~188~~ <sup>189</sup> ~~190~~ <sup>191</sup> ~~192~~ <sup>193</sup> ~~194~~ <sup>195</sup> ~~196~~ <sup>197</sup> ~~198~~ <sup>199</sup> ~~200~~ <sup>201</sup> ~~202~~ <sup>203</sup> ~~204~~ <sup>205</sup> ~~206~~ <sup>207</sup> ~~208~~ <sup>209</sup> ~~210~~ <sup>211</sup> ~~212~~ <sup>213</sup> ~~214~~ <sup>215</sup> ~~216~~ <sup>217</sup> ~~218~~ <sup>219</sup> ~~220~~ <sup>221</sup> ~~222~~ <sup>223</sup> ~~224~~ <sup>225</sup> ~~226~~ <sup>227</sup> ~~228~~ <sup>229</sup> ~~230~~ <sup>231</sup> ~~232~~ <sup>233</sup> ~~234~~ <sup>235</sup> ~~236~~ <sup>237</sup> ~~238~~ <sup>239</sup> ~~240~~ <sup>241</sup> ~~242~~ <sup>243</sup> ~~244~~ <sup>245</sup> ~~246~~ <sup>247</sup> ~~248~~ <sup>249</sup> ~~250~~ <sup>251</sup> ~~252~~ <sup>253</sup> ~~254~~ <sup>255</sup> ~~256~~ <sup>257</sup> ~~258~~ <sup>259</sup> ~~260~~ <sup>261</sup> ~~262~~ <sup>263</sup> ~~264~~ <sup>265</sup> ~~266~~ <sup>267</sup> ~~268~~ <sup>269</sup> ~~270~~ <sup>271</sup> ~~272~~ <sup>273</sup> ~~274~~ <sup>275</sup> ~~276~~ <sup>277</sup> ~~278~~ <sup>279</sup> ~~280~~ <sup>281</sup> ~~282~~ <sup>283</sup> ~~284~~ <sup>285</sup> ~~286~~ <sup>287</sup> ~~288~~ <sup>289</sup> ~~290~~ <sup>291</sup> ~~292~~ <sup>293</sup> ~~294~~ <sup>295</sup> ~~296~~ <sup>297</sup> ~~298~~ <sup>299</sup> ~~300~~ <sup>301</sup> ~~302~~ <sup>303</sup> ~~304~~ <sup>305</sup> ~~306~~ <sup>307</sup> ~~308~~ <sup>309</sup> ~~310~~ <sup>311</sup> ~~312~~ <sup>313</sup> ~~314~~ <sup>315</sup> ~~316~~ <sup>317</sup> ~~318~~ <sup>319</sup> ~~320~~ <sup>321</sup> ~~322~~ <sup>323</sup> ~~324~~ <sup>325</sup> ~~326~~ <sup>327</sup> ~~328~~ <sup>329</sup> ~~330~~ <sup>331</sup> ~~332~~ <sup>333</sup> ~~334~~ <sup>335</sup> ~~336~~ <sup>337</sup> ~~338~~ <sup>339</sup> ~~340~~ <sup>341</sup> ~~342~~ <sup>343</sup> ~~344~~ <sup>345</sup> ~~346~~ <sup>347</sup> ~~348~~ <sup>349</sup> ~~350~~ <sup>351</sup> ~~352~~ <sup>353</sup> ~~354~~ <sup>355</sup> ~~356~~ <sup>357</sup> ~~358~~ <sup>359</sup> ~~360~~ <sup>361</sup> ~~362~~ <sup>363</sup> ~~364~~ <sup>365</sup> ~~366~~ <sup>367</sup> ~~368~~ <sup>369</sup> ~~370~~ <sup>371</sup> ~~372~~ <sup>373</sup> ~~374~~ <sup>375</sup> ~~376~~ <sup>377</sup> ~~378~~ <sup>379</sup> ~~380~~ <sup>381</sup> ~~382~~ <sup>383</sup> ~~384~~ <sup>385</sup> ~~386~~ <sup>387</sup> ~~388~~ <sup>389</sup> ~~390~~ <sup>391</sup> ~~392~~ <sup>393</sup> ~~394~~ <sup>395</sup> ~~396~~ <sup>397</sup> ~~398~~ <sup>399</sup> ~~400~~ <sup>401</sup> ~~402~~ <sup>403</sup> ~~404~~ <sup>405</sup> ~~406~~ <sup>407</sup> ~~408~~ <sup>409</sup> ~~410~~ <sup>411</sup> ~~412~~ <sup>413</sup> ~~414~~ <sup>415</sup> ~~416~~ <sup>417</sup> ~~418~~ <sup>419</sup> ~~420~~ <sup>421</sup> ~~422~~ <sup>423</sup> ~~424~~ <sup>425</sup> ~~426~~ <sup>427</sup> ~~428~~ <sup>429</sup> ~~430~~ <sup>431</sup> ~~432~~ <sup>433</sup> ~~434~~ <sup>435</sup> ~~436~~ <sup>437</sup> ~~438~~ <sup>439</sup> ~~440~~ <sup>441</sup> ~~442~~ <sup>443</sup> ~~444~~ <sup>445</sup> ~~446~~ <sup>447</sup> ~~448~~ 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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6004**

**560**  
**6004**

1. NAME OF DECEASED (Type or Print) <b>JEANIE HENRY</b>		2. DATE OF DEATH <b>7-7-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>West Baltimore General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1604 St. Paul St. #2</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAY 11, 1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	9. AGE (In years last birthday) <b>66 65</b>
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>(Unknown) Black</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Burnington Funeral Home, Dayton Ohio</b>		ADDRESS	
18. <b>443X</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST,		(A) <b>Softening, congestion, enlargement of cerebral hemispheres</b> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) <b>Cerebral hemorrhage</b> DUE TO	
19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION (C) <b>Hypertensive arteriosclerosis, decubal ulcer pneumonia st. lung</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <b>7-5-1950</b> to <b>7-7-1950</b> that I last saw the deceased alive on <b>7-7-1950</b> , and that death occurred at <b>8:30 p. m.</b> , from the causes and on the date stated above.	
23A. SIGNATURE <b>Muriel S. Daly</b>		23B. ADDRESS <b>West Baltimore Gen. Hosp</b>	
23C. DATE SIGNED <b>7-8-50</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24B. DATE <b>7/8/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mound Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Caton Ohio</b>		25. FUNERAL DIRECTOR <b>Wm. G. Gohard</b>	
25. ADDRESS <b>124 St Paul St</b>		DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 8-1950</b>	
REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>		VS 150	

MEDICAL CERTIFICATION

**63399 6005**  
**108**

CERTIFICATE OF DEATH

LAST NAME

FIRST NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DECEASED'S SIGNATURE

DECEASED'S ADDRESS

DECEASED'S OCCUPATION

DECEASED'S RELIGION

DECEASED'S MARITAL STATUS

DECEASED'S EDUCATION

DECEASED'S RACE

DECEASED'S SEX

DECEASED'S HEIGHT

DECEASED'S WEIGHT



250  
50 6005BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

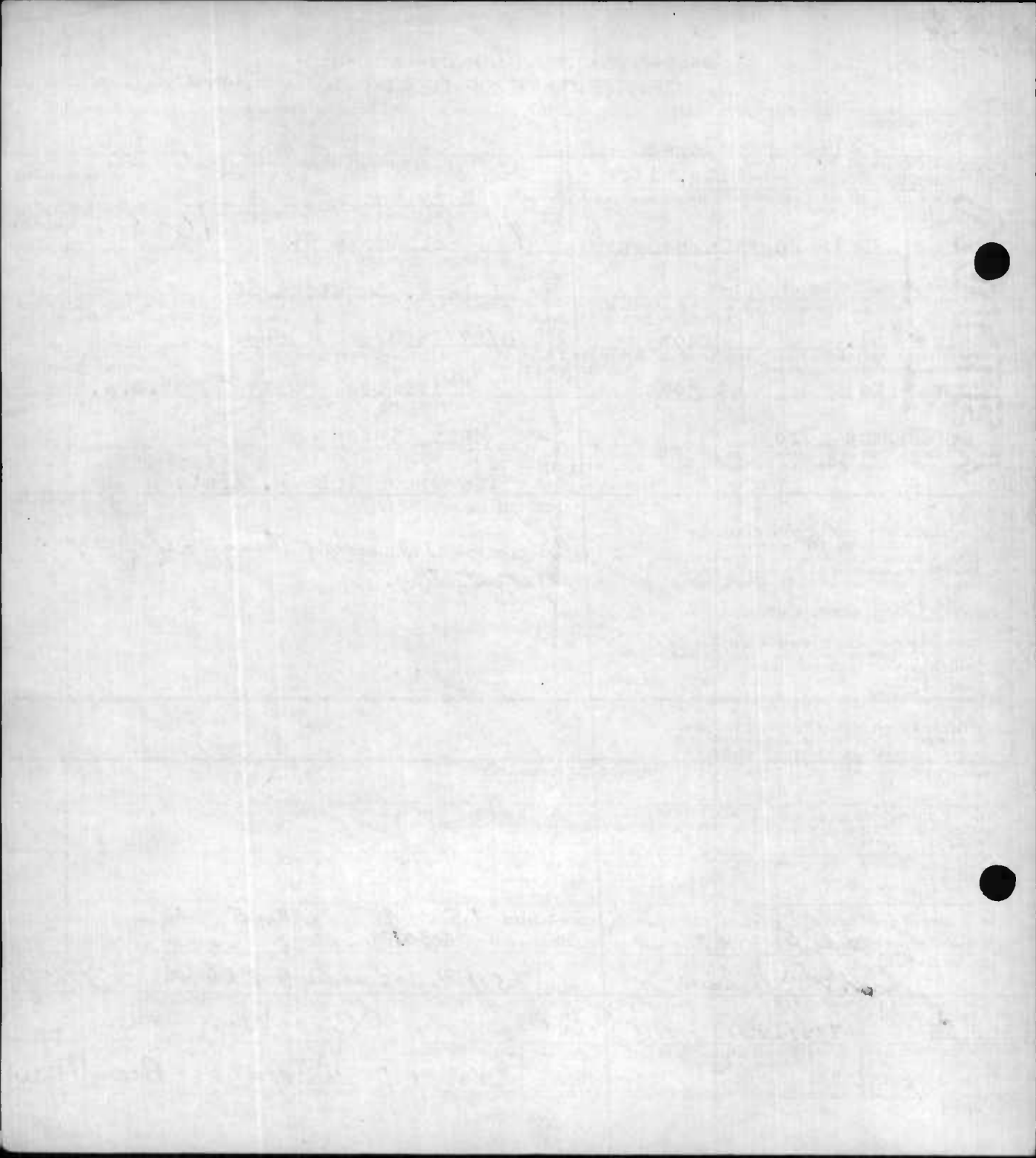
50 6005

Registered No. \_\_\_\_\_

BIRTH NO. _____		2. DATE OF DEATH <u>7/5/1950</u>	
1. NAME OF DECEASED (Type or Print) <u>Ella Towson</u>		3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. City</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>1012 West Saratoga St</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore City</u> D. STREET ADDRESS (If rural, give location) <u>1012 W. Saratoga St</u>	
c. Length of stay in Baltimore <u>Life</u>	5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	8. DATE OF BIRTH <u>6/27/1892</u>	9. AGE (in years last birthday) <u>58</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Thomas Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Ida Green</u>		ADDRESS <u>1012 W. Saratoga St</u>	

18. <u>171X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of Cervix + uterus with Metastasis.</u> CAUSE OF DEATH (A) <u>Carcinoma of Cervix + uterus with Metastasis.</u> DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____	

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>June 15, 1948</u> , to <u>July 5, 1950</u> , that I last saw the deceased alive on <u>July 5, 1950</u> , and that death occurred at <u>6:30 PM</u> from the causes and on the date stated above.					
23A. SIGNATURE <u>Dr. S. Julian</u>		23B. ADDRESS <u>511 N. Schroeder St. Baltimore</u>		23C. DATE SIGNED <u>7/7/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/9/1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Grt Calvary Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore Md</u>		24E. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>		ADDRESS <u>1000 Brantley Ave</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 8 - 1950</u>		REGISTRAR'S SIGNATURE <u>William Williams, Jr.</u>		48a	



530  
50 6006BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6006  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>John Lisbon Smith</i>		2. DATE OF DEATH <i>July 6, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>7-05</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1810 E. Madison St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>45 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>1810 E. Madison St.</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 15, 1885</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>65</i>
11. BIRTHPLACE (State or foreign country) <i>Pa</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Henry Smith</i>		14. MOTHER'S MAIDEN NAME <i>Kate Allen</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-07-423</i>	
17. INFORMANT <i>Susie Smith</i>		ADDRESS <i>1810 Madison St</i>	

18. <i>332X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cerebral Thrombosis</i> DUE TO (B) <i>Congestive Heart Failure</i> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>2 months</i>
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 19, 1950</i> , to <i>July 6, 1950</i> , that I last saw the deceased alive on <i>July 6, 1950</i> , and that death occurred at <i>8:10 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>R. W. M. Daniel</i>		23B. ADDRESS <i>807 N. Caroline St</i>		23C. DATE SIGNED <i>7-5-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 9/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>U. G. County Md</i>		25. FUNERAL DIRECTOR <i>Mrs. Robert A. Elliott</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 8 - 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, Md</i>		ADDRESS <i>1129 N. Caroline St</i>	

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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50 6007  
E-610  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>JOHN N. ERB, Jr.</b>		2. DATE OF DEATH <b>7/8/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>University Hosp.</b> B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <b>Westminster Md.</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>5600</b> D. STREET ADDRESS (If rural, give location) <b>Westminster R. 6</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		5. SEX <b>male</b> 6. COLOR OR RACE <b>W</b> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b> 8. DATE OF BIRTH <b>8/31 1943</b> 9. AGE (In years last birthday) <b>6 1/2</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY <b>✓</b> 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Erb</b>		14. MOTHER'S M maiden name <b>Edna A. Liedrich</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Fr. J. Reese Westminster</b>	

18. <b>204.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Leukemia</b> CAUSE OF DEATH (A) <b>Acute Leukemia</b> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
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19A. DATE OF OPERATION <b>7/11/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/5 1950</b> to <b>7/8 1950</b> , that I last saw the deceased alive on <b>7/8 1950</b> , and that death occurred at <b>8:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>James M. Bisnar</b> M. O.		23B. ADDRESS <b>University Hospital</b>		23C. DATE SIGNED <b>7/8/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/11/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Finksburg Cem</b>	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR <b>F. A. SHARTER</b>		ADDRESS <b>Westminster</b>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Montgomery Williams, M.D.</b>		74a md	

JUL 9 1950

6000

RECEIVED  
CENTRAL INTELLIGENCE AGENCY  
WASHINGTON, D.C. 20505





50 6008

50 6008

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

K-570  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>SARAH KNOFF</b>			2. DATE OF DEATH <b>7-7-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2305 St Paul St</b>			4. USUAL RESIDENCE Where deceased lived. If institution: residence before admission A. STATE <b>md</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>St Paul Convalescent Home Baltimore</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>3-018</b>		
D. STREET ADDRESS (If rural, give location) <b>432 So Caroline St</b>			E. LENGTH OF STAY IN BALTIMORE <b>60</b> Yrs. <b>None</b> Days		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>85</b>		9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Austria</b>
13. FATHER'S NAME <b>Not known</b>			14. MOTHER'S MAIDEN NAME <b>Not known</b>		12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Louis Siegel</b> ADDRESS <b>2009 Elsinore Ave</b>

18. <b>153X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <b>Hypertension</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) <b>carcinoma, large bowel</b> DUE TO	<b>1 yr</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(B) <b>malnutrition.</b> DUE TO	<b>1 yr</b>
(C)		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 6, 1950</b> , to <b>July 7, 1950</b> , that I last saw the deceased alive on <b>July 6, 1950</b> , and that death occurred at <b>7:54 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>E. Ellsworth Code</b>		23B. ADDRESS <b>2431 Maryland Ave.</b>		23C. DATE SIGNED <b>7/7/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7-9-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Ches. Shalom</b>	
24D. LOCATION (City, town, or county) <b>Balto, Md</b>		24E. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>		24F. ADDRESS <b>2100 Eutaw Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 9-1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>	

Mr Cook

2431 7th Ave.

50 6009

50 6009

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

J-212

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BESSIE JACOBSON

2. DATE  
OF  
DEATH

7-8-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Esplanade apts 108

C. Length of stay in Baltimore

5. SEX

Female white

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived, if institution; residence  
before admission)  
A. STATE B. COUNTY

Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore 15-05

D. STREET ADDRESS (If rural, give location)

3426 Toga Parkway

8. DATE OF BIRTH

9. AGE (In years,  
last birthday)

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

Russia

14. MOTHER'S MAIDEN NAME

not known

17. INFORMANT

Israel Jacobson - Same

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Acute Pulmonary Edema 4 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension &amp; coronary 5 years

(C) DUE TO

thrombosis 5 yrs

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1950, to July 8, 1950, that I last saw the  
deceased alive on July 8, 1950, and that death occurred at 10:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-9-50

Beth T Teloh

Baltimore Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 9-1950

Charles J. Williams, M.D.

Jack Lewis 2100 Canton Rd

VS 150

94a

MEDICAL CERTIFICATION

Silver/G  
Tampico Gardens

2-524

50 6010

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6010

Registered No.

1. NAME OF DECEASED (Type or Print) <i>MRS. MOLLIE W. LANGELOTTIG</i>		2. DATE OF DEATH <i>July 8, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Edgewood Nursing Home</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Edgewood Nursing Home</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 15-10</i>	
c. Length of stay in Baltimore Yrs. <i>1</i> Mos. <i>1</i> Days <i>1</i>		D. STREET ADDRESS (If rural, give location) <i>4101 Belview Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Feb. 28, 1867</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>83</i>
13. FATHER'S NAME <i>James Welslager</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Mollie Comfort Welslager</i>	
17. INFORMANT <i>Son (Albert Langeluttig)</i>		ADDRESS	

18. *442X*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) *Chronic Nephritis & Anemia*  
DUE TO

(B) *Arteriosclerotic Hyper-tension*  
DUE TO

(C) *Cardio-Vascular Renal Disease*  
DUE TO

(D) *None*

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>March 1950</i> to <i>July 8, 1950</i> , that I last saw the deceased alive on <i>July 8, 1950</i> , and that death occurred at <i>2 A. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>M. Langeluttig</i>		23B. ADDRESS <i>715 W. Charles St</i>		23C. DATE SIGNED <i>July 8, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 10, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		24E. FUNERAL DIRECTOR <i>Maime C. Syfer</i>		24F. ADDRESS <i>1600 N. North Ave</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>9-1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Maime C. Syfer</i>	

STATE OF CALIFORNIA  
DEPARTMENT OF AGRICULTURE

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



C-512

50 6011

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6011

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annetta Coombs

2. DATE  
OF  
DEATH

7/8/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

38 S. Fulton Ave

C. CITY OR TOWN

Balti.

(If outside corporate limits, write RURAL and give township)

19-04

HOSPITAL OR INSTITUTION

D. STREET ADDRESS (If rural, give location)

38 S. Fulton Ave

C. Length of stay in Baltimore

30

Yrs.

Mon.

Days

5. SEX

F.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

JAN 1870

9. AGE (in years last birthday)

80

H Under 1 Year

Months: Days

H Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

H.W.

10B. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Kemptner

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Wm. Coombs, 38 S. Fulton Ave

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation

3 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio-vascular disease

?

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐

WORK AT WORK

22. I hereby certify that I attended the deceased from Jan., 1948, to July 4, 1950, that I last saw the deceased alive on July 4, 1950, and that death occurred at 2 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

July 8, 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 9 1950

Harry F. Witzke, M.D.

Harry F. Witzke, 4101 Edmondson Ave

931 Ave

Mr. Glassman 7.30.

753 W. Jayette St.

K-412  
50 6012BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX 50 6012  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MAUDE KAL BAUGH</b>		2. DATE OF DEATH <b>July 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Md.</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Alleghany</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hosp</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>RURAL - LUKE</b>	
C. Length of stay in Baltimore <b>2 mos 4 days</b>		D. STREET ADDRESS (If rural, give location) <b>LUKE 5100</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>6/4</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES POLAND</b>		14. MOTHER'S MAIDEN NAME <b>NORA GIRARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>PATIENT</b>	
17. INFORMANT <b>LUKE</b>		ADDRESS <b>Md.</b>	

18. <b>585X 002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intracerebral hemorrhage</b> (A) DUE TO	CAUSE OF DEATH <b>Intracerebral hemorrhage</b>	INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <b>Arteriosclerosis</b> DUE TO	<b>Arteriosclerosis</b>	<b>-</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) <b>Pneumonia; Tuberculosis</b>	<b>Pneumonia; Tuberculosis</b>	<b>10-12 days</b>
19A. DATE OF OPERATION <b>6-23-50 3</b>	19B. MAJOR FINDINGS OF OPERATION <b>Chronic cholecystitis</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 1**, 19**50**, to **July 9**, 19**50**, that I last saw the deceased alive on **July 9**, 19**50**, and that death occurred at **12:01A** m., from the causes and on the date stated above.

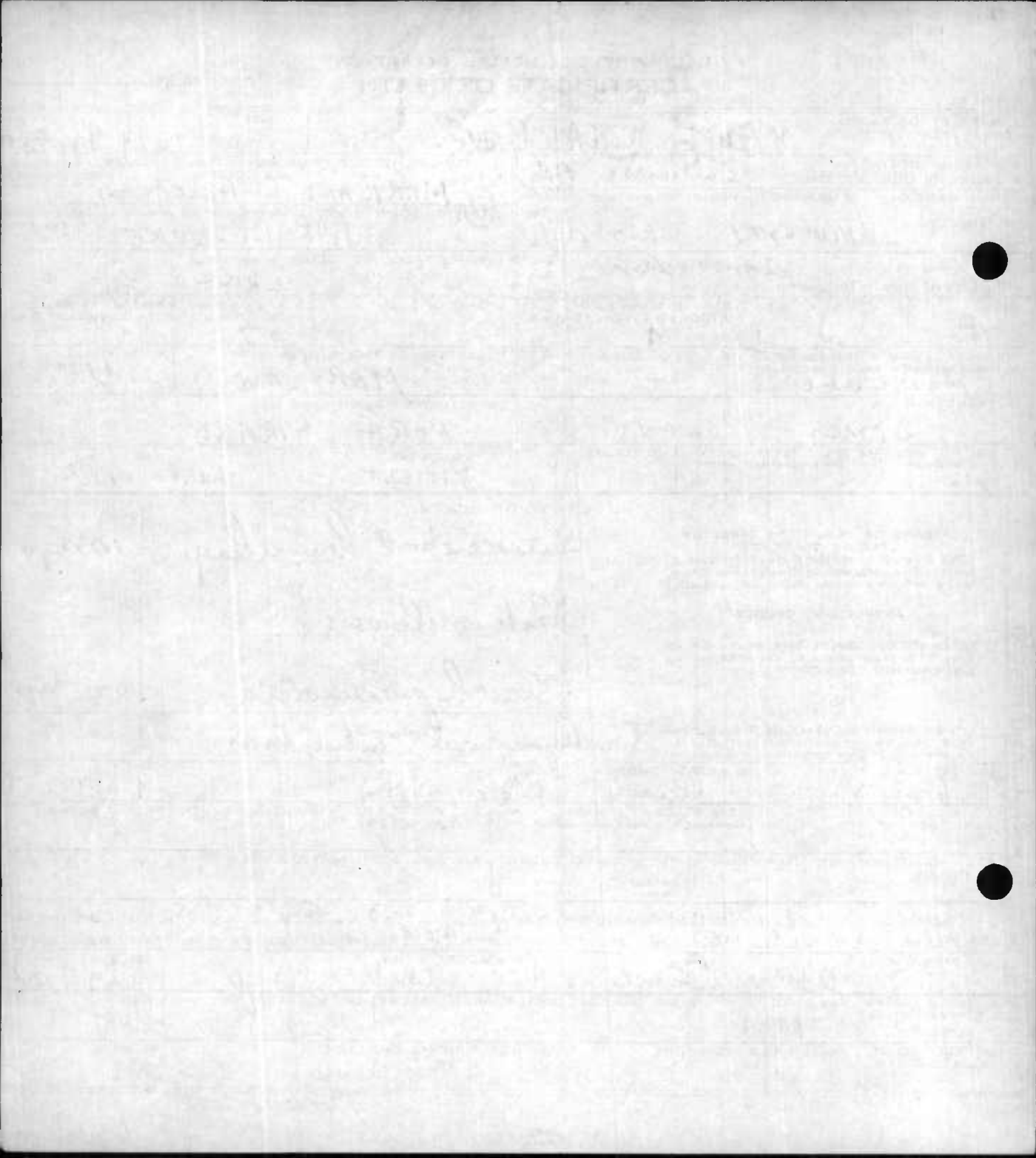
23A. SIGNATURE **Danien Glaser M. D.** 23B. ADDRESS **Univ Hosp** 23C. DATE SIGNED **July 9, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/13/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Waterbrook</b>	24D. LOCATION (City, town, or county) (State) <b>Waterbrook Md.</b>
---	--------------------------	--	---

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 9 - 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. J. Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. J. Lickner &amp; Sons, Inc.</b>	ADDRESS <b>Balto 12, Md.</b>
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6013

127a



R-220

50 6013

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6013

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RAYMOND J. RAZACK</b>		2. DATE OF DEATH <b>7/7/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTO.</b> <b>23-02</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1518 S. CHARLES ST.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Dec.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) Months Days <b>69</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Vincent Razack</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Emma J. Razack</b>		ADDRESS <b>1518 S. Charles</b>	

18. **446X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) **Arteriole nephrosclerosis with**  
DUE TO **generalized arteriosclerosis**

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH  
**Wrenia**

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6/27/50</b> , to <b>7/7/50</b> , that I last saw the deceased alive on <b>7/6/50</b> , and that death occurred at <b>2:00 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Thaddeus Swinski</b> M. D.		23B. ADDRESS <b>St. Joseph's Hosp.</b>		23C. DATE SIGNED <b>7/7/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/10/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Balto.</b>	
24D. LOCATION (City, town, or county) (State) <b>Md.</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Balto.</b>		24F. LOCATION (City, town, or county) (State) <b>Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 9 - 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>Flynn + Fleming</b>	
VS 150		ADDRESS <b>1426 Light St.</b>		131a	

57424 6013





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 48-26570

1. NAME OF DECEASED  
(Type or Print)

RUSSELL P. CLARKE, JR.

2. DATE  
OF  
DEATH

7/7/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION SOUTH BALTO. GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY ANNE ARUNDEL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Glen Burnie 5200

D. STREET ADDRESS (If rural, give location)  
301 Third Avenue, S.E.

c. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

S

8. DATE OF BIRTH

Dec 2 1948

9. AGE (In years last birthday)

10. Under 1 Year  
Months: 19 Days: \_\_\_\_\_

11. Under 24 Hours  
Hours: \_\_\_\_\_ Min: \_\_\_\_\_

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY

NONE

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Russell Clarke

14. MOTHER'S MAIDEN NAME

Ruth Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

RUSSELL P. CLARK SY.

ADDRESS

GLEN BURNIE MD

18. 576 X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Peritonitis - generalized - organism undetermined

24 hrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Perforation of ileum - cause undetermined

24 hrs.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

7/7/50

19B. MAJOR FINDINGS OF OPERATION

Peritonitis Perforation of ileum

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/7/50, 1950, to 7/7/50, 1950, that I last saw the deceased alive on 7/7/50, 1950, and that death occurred at 9<sup>40</sup> A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

William B. Cooper, Jr. M.D.

South Baltimore General Hosp

7/7/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

JULY 10, 1950

GLEN HAVEN

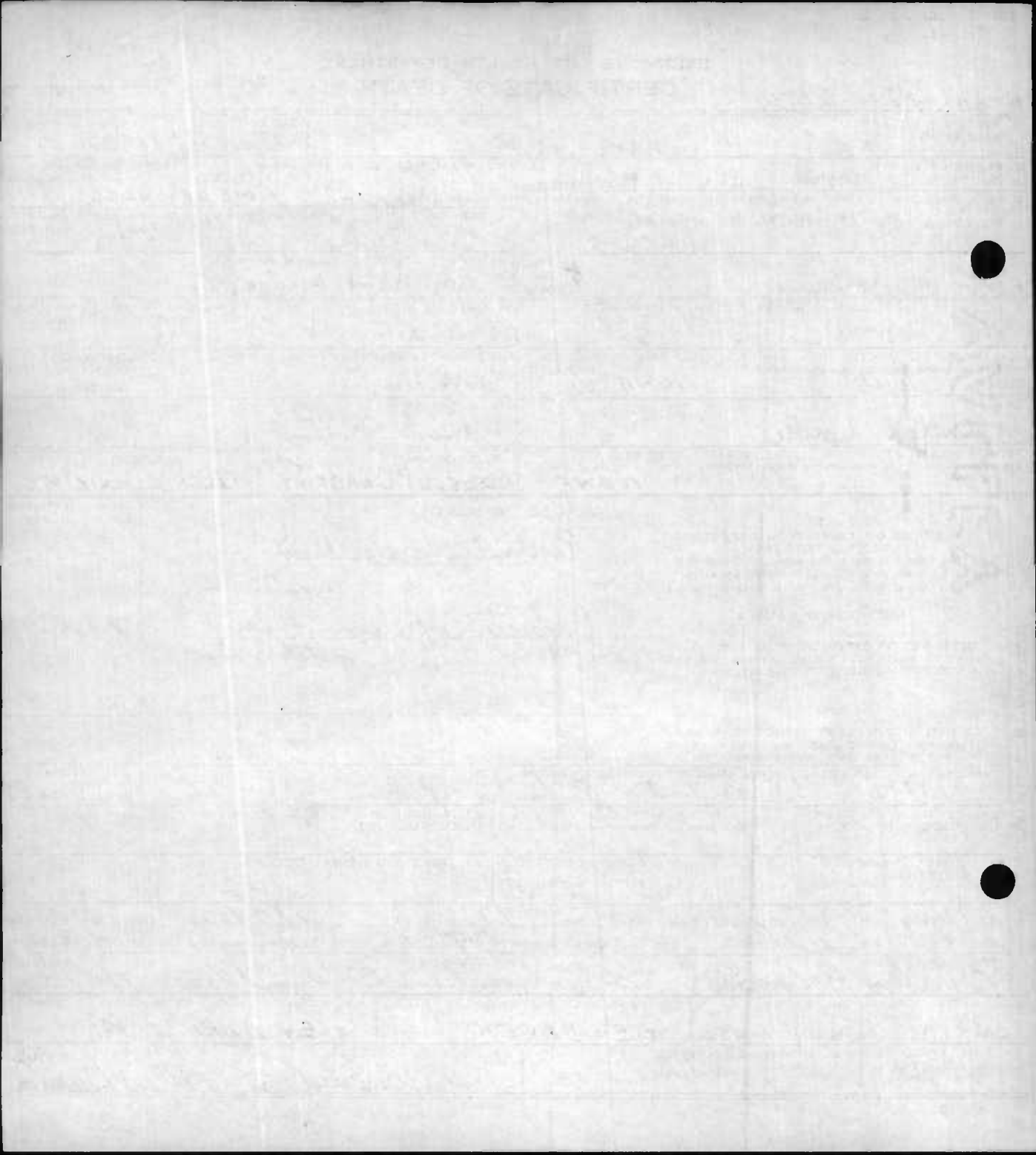
GLEN BURNIE, MD

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS



5-542  
REA-13871306015 BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6015  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

William O. Samuelson

2. DATE  
OF  
DEATH

July 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION location)Baltimore City Hospital  
4940 Eastern AvenueC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

27-04

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

1523 Light Street (1)

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Separated

8. DATE OF BIRTH

April 6, 1886

9. AGE (In years  
last birthday)

64

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR  
INDUSTRY

REGAL LAUNDRY

11. BIRTHPLACE (State or foreign country)

New Hampshire

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Oscar Samuelson

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

UNKNOWN

17. INFORMANT ADDRESS  
Records: Baltimore City Hospital  
4940 Eastern Avenue

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Bronchogenic Carcinoma

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

June 20, 1950

19B. MAJOR FINDINGS OF OPERATION

Bropsin of left supraclavicular lymph node

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 8, 1950, to July 7, 1950, that I last saw the  
deceased alive on July 7, 1950, and that death occurred at 6:55A m., from the causes and on the date stated above.

23A. SIGNATURE

*B. J. J. J.*

23B. ADDRESS

M. D. 4940 Eastern Avenue

23C. DATE SIGNED

July 7, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

July 10, 1950

24C. NAME OF CEMETERY OR CREMATORY

GLEN HAVEN

24D. LOCATION (City, town, or county)

GLEN BURNIE MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*William O. Samuelson*

25. FUNERAL DIRECTOR

Thomas W. Slaughter Glen Burnie, MD

ADDRESS

THESE ARE THE RESULTS OF THE  
ANALYSIS OF THE SAMPLES

656 50 6016

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6016  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Samuel Harner</i>		2. DATE OF DEATH <i>7/9/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>36 Franklin Square Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 7-04</i>			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1019 Broadway N.</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>Sept 10, 1903</i>	9. AGE (In years, last birthday) <i>46</i> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>janitor</i>		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Abia Harner</i>		14. MOTHER'S MAIDEN NAME <i>Annie Engeler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

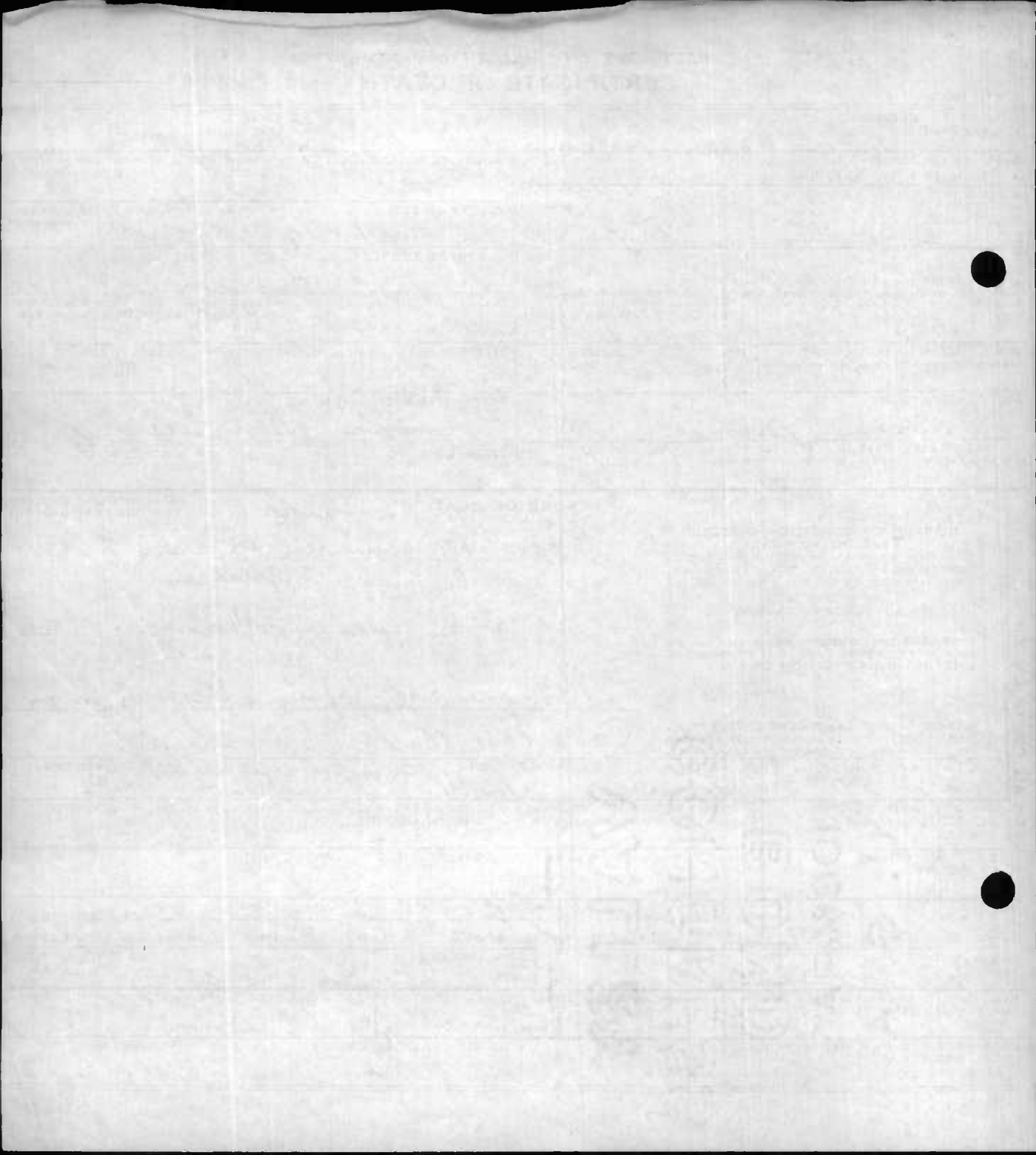
MEDICAL CERTIFICATION	18. <i>540 1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <i>left</i>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES		(A) <i>Bronchopneumonia extensive</i> DUE TO <i>antecedent</i>		
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Regurgitation blood and gastric</i> DUE TO <i>duodenal</i>		<i>3 days</i>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>Hemorrhage, peptic ulcer</i> <i>Calcific aortic valvulitis</i>		<i>6 mos</i>
19A. DATE OF OPERATION <i>7-7-50</i>		19B. MAJOR FINDINGS OF OPERATION <i>gastro-duodenal artery</i>			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., home or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>7-6-50</i> , 19 <i>50</i> , to <i>7-9</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-9</i> , 19 <i>50</i> , and that death occurred at <i>4:20</i> a.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>G.W. Borbore</i>		23B. ADDRESS <i>Franklin Sq. Bldg</i>		23C. DATE SIGNED <i>7-9-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>7/9/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel</i>	24D. LOCATION (City, town, or county) (State) <i>Littletown Pa.</i>	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <i>Wm. J. Williams</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm. J. Pickman &amp; Son Wash + Pa Ave</i>	

JUL 15 1950

77082

117a





340  
50 6017

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6017  
Registered No.

BIRTH NO. \_\_\_\_\_  
1. NAME OF DECEASED (Type or Print) **MARTHA** **BEDLEY** 2. DATE OF DEATH **July 9, 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland **Baltimore City Hospital**  
B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**13000 Ind 15-03**

4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)  
A. STATE **1628 Thomas Ave**  
B. COUNTY  
C. STREET ADDRESS (If rural, give location)  
**1628 Thomas Ave**

5. SEX **FEMALE** 6. COLOR OR RACE **WHITE** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Single**  
8. DATE OF BIRTH **July 7 - 1926** 9. AGE (In years last birthday) **24**  
10. USUAL OCCUPATION (Give kind of work done during most of working life, or as if retired) **Clerk - S.S. Board U.S. GOVT.** 11. BIRTHPLACE (State or foreign country) **Washington Pa.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **John - Bedley -** 14. MOTHER'S MAIDEN NAME **Mary - Sigalia**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, give unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. \_\_\_\_\_  
17. INFORMANT **John Bedley - Washington Pa** ADDRESS \_\_\_\_\_

18. **E816.1** CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**SUBDURAL HEMATOMATA**  
DUE TO  
ANTECEDENT CAUSES  
**MULTIPLE CONTUSIONS**  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
DUE TO

19A. DATE OF OPERATION **July 9, 1950** 19B. MAJOR FINDINGS OF OPERATION  
20. AUTOPSY? YES ☒ NO ☐  
21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **on Highway** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **6800 Block, Pulaski Highway**  
21D. TIME (Month) (Day) (Year) (Hour) **JULY 9, 1950 AM** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Passenger in car that hit parked truck.**

22. I certify that I took charge of the remains described above, held an **AUTOPSY** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE **Stanley H. Durlacher, M.D.** 23B. CHIEF MEDICAL EXAMINER ☐ 23C. DATE SIGNED **July 9, 1950**  
ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **July 12-50** 24C. NAME OF CEMETERY OR CREMATORY **Oak Springs** 24D. LOCATION (City, town, or county) (State) **Annarsburg Pa.**  
DATE RECEIVED BY LOCAL REGISTRAR **July 10 1950** REGISTRAR'S SIGNATURE **Wilmington Williams, MD** 25. FUNERAL DIRECTOR **Esleworth Annarsburg** ADDRESS **1700**

VS 151 **N-854** **390 91** **5118** **Swann Oak Ave**

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Signature of Coroner		Signature of Medical Examiner	
Signature of Burial Officer		Signature of Cemetery	
Signature of Undertaker		Signature of Funeral Home	
Signature of Family		Signature of Friends	
Signature of Church		Signature of Community	
Signature of Government		Signature of State	
Signature of Nation		Signature of World	

500  
60 6018

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6018

1. NAME OF DECEASED (Type or Print) <b>KATHERINE HAMM</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2706 Pelham Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2706 Pelham Ave</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6/22/1867</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>83</b>
13. FATHER'S NAME <b>John C. Distler</b>		14. MOTHER'S MAIDEN NAME <b>Margaret (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>24006</b>	
17. INFORMANT <b>Sabina Greenwald Pelham Ave</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. CITIZEN OF WHAT COUNTRY?	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>Cardio-Vascular-Hypertensive Disease</b> DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours.</b> <b>11 years</b> <b>11 years.</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
24. TIME (Month) (Day) (Year) (Hour) OF INJURY		25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
26. HOW DID INJURY OCCUR?		27. I hereby certify that I attended the deceased from <b>March</b> , 1939, to <b>July 8</b> , 1950, that I last saw the deceased alive on <b>July 8</b> , 1950, and that death occurred at <b>1:40 P. m.</b> , from the causes and on the date stated above.	
28. SIGNATURE <b>Michael J. Dausch</b>		29. ADDRESS <b>4636 Belair Road</b>	
30. DATE <b>7/11/50</b>		31. DATE SIGNED <b>7/8/50</b>	
32. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		33. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
34. LOCATION (City, town, or county) (State) <b>Eastern Ave. Extended</b>		35. FUNERAL DIRECTOR <b>Wm Cook Inc. 1217 St. Paul st.</b>	
36. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		37. REGISTRAR'S SIGNATURE <b>Thurston Williams</b>	

MEDICAL CERTIFICATION

STATEMENT OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH OF SPOUSE

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

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DATE OF BIRTH OF CHILDREN

NAME OF CHILDREN

DATE OF BIRTH OF CHILDREN

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0 6019

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6019

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MARY E. SMITH</i>		2. DATE OF DEATH <i>7-9-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BALTIMORE 27-17</i>			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>3204 HAYWOOD Ave</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <i>9-9-1892</i>	9. AGE (in years last birthday) <i>58</i>
10A. USUAL OCCUPATION (Give kind of work done during most of work log life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>WILLIAM H. HOWARD</i>		14. MOTHER'S MAIDEN NAME <i>MARY E. HOLLAND</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>JAMES G. McNEIR 3204 HAYWOOD Ave</i>	

MEDICAL CERTIFICATION

18. <i>581.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Thrombosis &amp; Intracerebral Hemorrhage &amp; Cirrhosis of Liver</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>BRONCHOPNEUMONIA</i>		<i>Hrs</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>See "C" above</i>		

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 20, 1950</i> , to <i>July 9, 1950</i> , that I last saw the deceased alive on <i>July 9, 1950</i> , and that death occurred at <i>8:30 AM</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Francis J. Boyce</i>		23B. ADDRESS <i>2528 Maryland Ave. - 18</i>		23C. DATE SIGNED <i>7/9/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/12/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>	
				24D. LOCATION (City, town, or County) (State) <i>Pikesville Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 10 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Carl Ebeling, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook Inc. 1217 St. Paul St.</i>	

VS 150  
23 A. Wm. Carl Ebeling, M.D. 124 B

RECEIVED OF THE





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6020  
Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>MARIAN CYNTHIA WILLOWER.</u>		2. DATE OF DEATH <u>7/15/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Women's Hospital.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>27-11</u>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <u>326 Rosette Ave</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED</del> (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/29/87</u>	9. AGE (In years last birthday) <u>62</u>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Mac Henry Fraser.</u>		14. MOTHER'S MAIDEN NAME <u>Florence - Moon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Miss Marian Dickerson 2624 St. Paul St. Daughter.</u>	

18. <u>260X</u> <u>E950X</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Relioperitoneal Hemorrhage -</u> DUE TO _____ (A) _____ (B) _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>(over)</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus: Gangrene Right Foot</u>	

19A. DATE OF OPERATION <u>7/10/50</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/6/50</u> , 19 <u>50</u> , to <u>7/12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7/15/50</u> , 19 <u>50</u> , and that death occurred at <u>7:45</u> a.m., from the causes and on the date stated above.					
23A. SIGNATURE <u>Mark E. Hall, Jr.</u>		23B. ADDRESS <u>Women's Hosp.</u>		23C. DATE SIGNED <u>7/15/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/10/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 10 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. C. Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>Wm. C. Williams, M.D.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MEDICAL CERTIFICATION

061

for  
query, underlying

Cause of retroperitoneal hemorrhage

Traumatic puncture of right renal vein  
during paravertebral lumbar sympathetic  
nerve block - A therapeutic procedure

See Document File 50 - 6020

10-9-50

EC

653 MM 138815 50 6021		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 6021 Registered No. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>Harry, B. Barnett.</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>15-06</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR <b>Baltimore City Hospitals</b> INSTITUTION <b>4940 Eastern Ave</b>		D. STREET ADDRESS (If rural, give location) <b>1613 Dukeland St, Z 16</b>		9. AGE (In years last birthday) <b>73</b> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.	
c. Length of stay in Baltimore <b>30 years</b>		8. DATE OF BIRTH <b>June 1, 1877</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		12. CITIZEN OF WHAT COUNTRY?	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>	
13. FATHER'S NAME <b>Henry, Barnett</b>		14. MOTHER'S MAIDEN NAME <b>Narcissica, McIlwaine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Records B.C.H. 4940 Eastern Ave.</b>		ADDRESS _____	
18. <b>610X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Retroperitoneal Abscess</b> (A) _____ DUE TO _____ (B) _____ DUE TO _____ (C) _____ INTERVAL BETWEEN ONSET AND DEATH _____		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____ (C) _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19A. DATE OF OPERATION <b>6-29-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Benign Prostatic Hypertrophy</b>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6-12-50</b> , 19____, to <b>7-8-50</b> , 19____, that I last saw the deceased alive on <b>7-8-50</b> , 19____, and that death occurred at <b>9:22 AM</b> , from the causes and on the date stated above.		23A. SIGNATURE <b>Dr. Crozer</b> M. D.		23B. ADDRESS <b>4940 Eastern Ave.</b>	
23C. DATE SIGNED <b>7-8-1950</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>7/10/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		24D. LOCATION (City, town, or county) <b>Balto. Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>	
REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>40th Cook Inc 1217 St. Paul St.</b>		ADDRESS _____	
VS 150		490990022		137a	

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# CERTIFICATE CORRECTED

7-13-50

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 6022

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOLLY S. PYBAS</b>			2. DATE OF DEATH <b>July 7, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>27 N. Carey St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>12-04</b>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>312 E. 20th St.</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>May 23, 1913</b> <b>May 22, 1910</b>	9. AGE (In years last birthday) <b>37 49</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Braider, wire</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
13. FATHER'S NAME <b>Henry Stewart</b>			14. MOTHER'S MAIDEN NAME <b>Mary (Unknown)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>234-10-0458</b>		17. INFORMANT ADDRESS <b>Mrs Henry Pleasant, 425 E. 20th St.</b>	

18. <b>171X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the cervix with metastases.</b>		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO	
		(C)	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>30 June, 1950</b> to <b>7 July, 1950</b> , that I last saw the deceased alive on <b>7 July, 1950</b> , and that death occurred at <b>7 P. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Emil H. Henning Jr.</b> M. D.		23B. ADDRESS <b>601 W. Indiana Way</b>		23C. DATE SIGNED <b>8 July 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/11/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>W. M. Cook Inc 1219 St Paul St</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <b>W. M. Cook</b>		VS 150	

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WALTER

Carroll's arrival  
and departure

of the 1st of June 1861  
at the residence of  
Mr. J. W. Carroll  
at the residence of  
Mr. J. W. Carroll  
at the residence of  
Mr. J. W. Carroll



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 6023

50 6023  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES W. GREIN</b>			2. DATE OF DEATH <b>July 8, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR <b>3025 Windsor Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-05</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>3025 Fleetwood Ave.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>July 25, 1877</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass Blower, retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Carr Laury Co</b>		
13. FATHER'S NAME <b>William H. Grein</b>			12. CITIZEN OF WHAT COUNTRY? <b>Pa.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <b>Mrs Elizabeth Hartman</b>			ADDRESS <b>3035 Fleetwood Ave.</b>		

18. <b>442X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Nephrosclerosis</b>		<b>1 year</b>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 15, 1950 to July 8, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 8:10 A. m., from the causes and on the date stated above.

23A. SIGNATURE Abraham B. Hurwitz M. D. 23B. ADDRESS 3048 W. North Ave. 23C. DATE SIGNED July 8, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE 7/11/50 24C. NAME OF CEMETERY OR CREMATORY Moreland Park 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1950 REGISTRAR'S SIGNATURE Thurston Williams 25. FUNERAL DIRECTOR 1211 St Paul St ADDRESS \_\_\_\_\_

— — — — —

1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

2. The second part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into a list format. The notes are written on a piece of paper that has been folded, and the edges of the folds are visible.

3. The third part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into a list format. The notes are written on a piece of paper that has been folded, and the edges of the folds are visible.

4. The fourth part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into a list format. The notes are written on a piece of paper that has been folded, and the edges of the folds are visible.

5. The fifth part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into a list format. The notes are written on a piece of paper that has been folded, and the edges of the folds are visible.

1891

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6024

Registered No.

BIRTH NO. 50 6024

1. NAME OF DECEASED (Type or Print) <b>NORMAN FRIEDENWALD</b>			2. DATE OF DEATH <b>July 9, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1701 No. Ellement St</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>INBLATTS NURSING HOME</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>		
c. Length of stay in Baltimore <b>LIFE</b>			D. STREET ADDRESS (If rural, give location) <b>3023 PRESSTMAN ST</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>76</b>		9. AGE (In years last birthday) <b>76</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>DR. AARON FRIEDENWALD</b>			14. MOTHER'S MAIDEN NAME <b>BERTHA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>BERTRICE FRIEDENWALD - 3023 PRESSTMAN ST</b>		

18. <b>420.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY THROMBOSIS</b> DUE TO <b>ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 YRS.</b>
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19A. DATE OF OPERATION <b>7/10/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Sept 1947</b> to <b>July 9, 1950</b> , that I last saw the deceased alive on <b>July 6, 1950</b> , and that death occurred at <b>10<sup>00</sup> A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>L. Emmett Green</b>		23B. ADDRESS <b>Med Bldg.</b>		23C. DATE SIGNED <b>7/9/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JULY 10, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE, HEBREW</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>		25. FUNERAL DIRECTOR ADDRESS <b>Jack Lewis Inc - 2100 EUTAW PL.</b>			

DATE RECEIVED BY LOCAL REGISTRAR **JUL 10 1950** REGISTRAR'S SIGNATURE **Wm. J. Williams, M.D.**

UNITED STATES DEPARTMENT OF HEALTH  
CENTRAL REGISTER OF DEATHS

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CITY

COUNTY

STATE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

CITY

COUNTY

STATE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

CITY

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

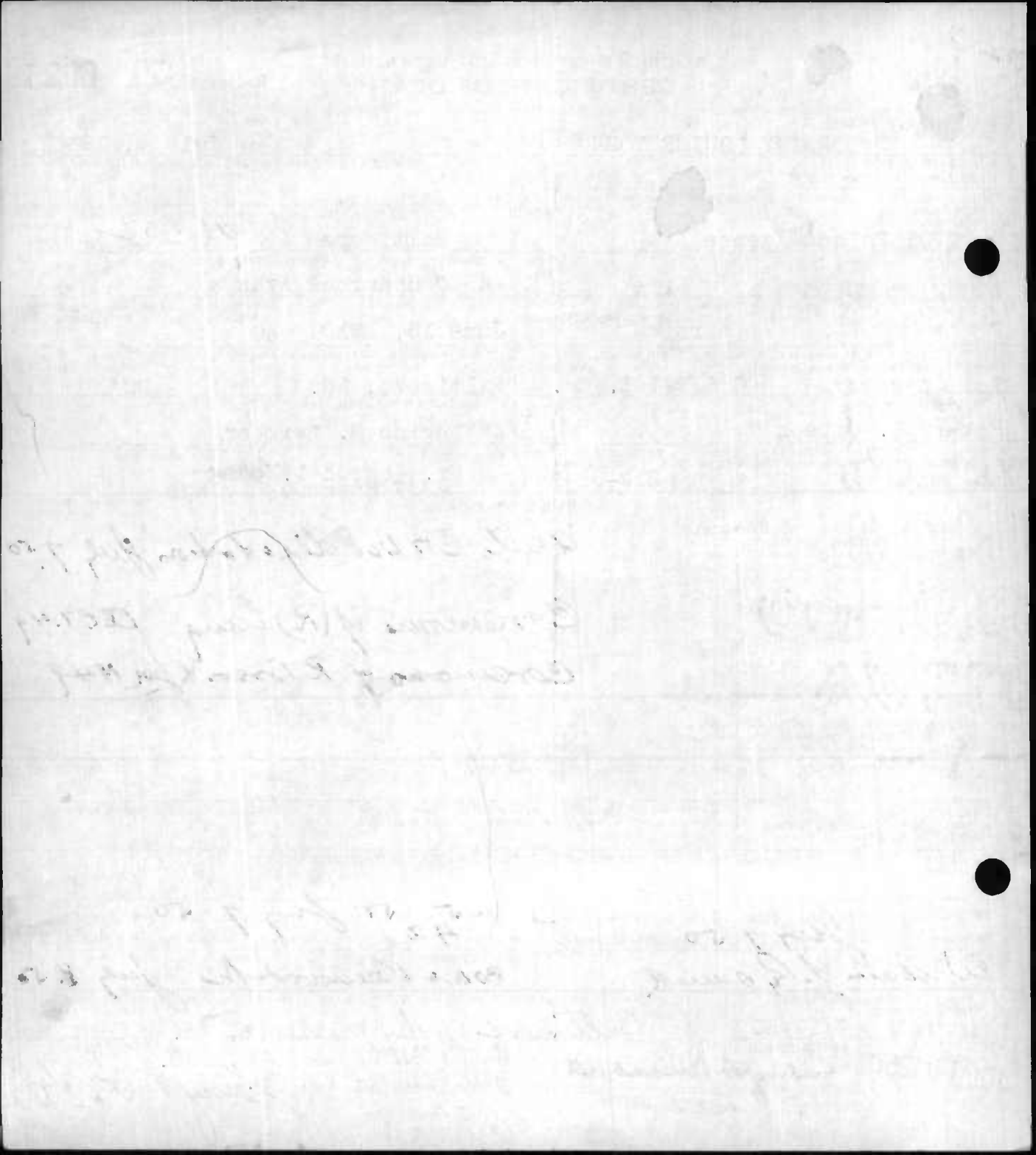
Registered No. 50 6025

520  
50 6025  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>DOROTHY LOUISE YOUNG</b>		2. DATE OF DEATH <b>July 7, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2701 Pelham Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>4347 Shamrock Avenue</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 10, 1910</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tel Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Tel. Co.</b>	9. AGE (in years last birthday) <b>40</b>
13. FATHER'S NAME <b>Robert S. Gibson</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>212-05-1847</b>		14. MOTHER'S MAIDEN NAME <b>Katherine M. Leimberg</b>	
17. INFORMANT <b>Mr. Joseph L. Young</b>		ADDRESS <b>4347 Shamrock Avenue</b>	

18. CAUSE OF DEATH <b>170x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Cordic dilatation July 7. 50</b> DUE TO (A) <b>Coronary H(R) Lung DEC 1. 49</b> (B) <b>Coronary R Bronch X Jan 1949</b> (C) <b>Coronary R Bronch X Jan 1949</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>6</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 5, 1950</b> to <b>July 7, 1950</b> , that I last saw the deceased alive on <b>July 7, 1950</b> and that death occurred at <b>4a</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>William J. P. Sander</b>		23B. ADDRESS <b>801 N. Kenwood Dr</b>		23C. DATE SIGNED <b>July 8. 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/10/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>		24F. ADDRESS <b>BALTIMORE - 13, MD</b>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6026

BIRTH NO. 6026

1. NAME OF DECEASED (Type or Print) <b>LOUISE MEEKINS</b>			2. DATE OF DEATH <b>June 28, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>4-02</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>651 W. Fairmount Avenue</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Dec. 6 1917</b>	9. AGE (In years last birthday) <b>32</b>	10. Under 1 Year Months: _____ Days: _____ 10. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
11. FATHER'S NAME <b>John Roy Branch</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Lucile Hughes</b>		
15. SOCIAL SECURITY NO. <b>no</b>			16. INFORMANT <b>Lucile Ellis &amp; Josephine Pt.</b>		

18. **002X**

**CAUSE OF DEATH**

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Far advanced bilateral pulmonary tuberculosis**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

(C) \_\_\_\_\_  
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE **Frank H. Duescher, M.D.** 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **June 29, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7/10/50** 24C. NAME OF CEMETERY OR CREMATORY **Mt Calvary** 24D. LOCATION (City, town, or county) **Eden Hill**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 10 1950** REGISTRAR'S SIGNATURE **Wm. H. Williams, Jr.** 25. FUNERAL DIRECTOR **W. Halstead** ADDRESS **918 N. David Hill Ave**



615		MURPHINE		X		50 6027	
00 6027		BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <b>MABEL MURPHINE</b>				2. DATE OF DEATH <b>July 9, 1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission) A. STATE <b>CAMDEN, N.J.</b> B. COUNTY <b>V-27</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or hospital or institution) <b>ST. JOSEPH'S HOSP. BALTO.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
C. Length of stay in Baltimore <b>7 DAYS</b>				D. STREET ADDRESS (If rural, give location) <b>2719 CRAMER ST.</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>		8. DATE OF BIRTH <b>March 31, 1881</b>	9. AGE (In years last birthday) <b>69</b>	H Under 1 Year Months: Days	H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>WOODSTOWN, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>ALFRED MC ALLISTER</b>				14. MOTHER'S MAIDEN NAME <b>DEBORAH CRISPIN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>RALPH F. MURPHINE</b>		ADDRESS <b>3616 WOODBINE</b>	
18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VAS. ACCIDENT</b> DUE TO <b>HYPERTENSION VAS.</b> DUE TO <b>—</b> DUE TO <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 9</b> , 19 <b>50</b> , to <b>—</b> , 19 <b>—</b> , that I last saw the deceased alive on <b>July 9</b> , 19 <b>50</b> , and that death occurred at <b>6 p. m.</b> , from the causes and on the date stated above.							
23A. SIGNATURE <b>E. G. Coffey Jr. M.D.</b>				23B. ADDRESS <b>St. Joseph's Hospital</b>		23C. DATE SIGNED <b>7/9/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 12-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sharptown N. J.</b>		24D. LOCATION (City, town, or county) (State) <b>Sharptown N. J.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Edgeworth Amacoast</b>		ADDRESS <b>5118 Sherrin Oak Ave.</b>	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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525 50 6028		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 6028 Registered No.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>AGNES JENKINS</b>		2. DATE OF DEATH <b>6 JULY 50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE - 12 27-10</b>			
c. Length of stay in Baltimore <b>LIFE</b>		D. STREET ADDRESS (If rural, give location) <b>510 RICHWOOD AVE</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>OCT 15, 1874</b>	9. AGE (In years last birthday) <b>75</b>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN JENKINS</b>		14. MOTHER'S MAIDEN NAME <b>JULIA E. EDWARDS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MRS. G. R. NINGARD 510 RICHWOOD AVE</b>	
18. <b>541.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Cardiac failure</b> DUE TO <b>ANTECEDENT CAUSES</b> (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) <b>Ref. of 1st part duodenum to pentonix Umb</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unk.</b>			
19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 5, 1950</b> , to <b>July 6, 1950</b> , that I last saw the deceased alive on <b>July 6, 1950</b> , and that death occurred at <b>10:14 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Oliver R. Reed</b>		23B. ADDRESS <b>Mercy Hospital</b>		23C. DATE SIGNED <b>July 6, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7-10-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD</b>	
24D. LOCATION (City, town, or county) <b>PARKVILLE</b>		24E. STATE <b>MD.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>H.W. JENKINS &amp; SONS Co 4905 YORK RD</b>	
VS 150					

MEDICAL CERTIFICATION

117B

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM

TO : DIRECTOR, FBI (100-441100)  
FROM : SAC, NEW YORK (100-100000)  
SUBJECT: [Illegible]

DATE: [Illegible]  
BY: [Illegible]



Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

D ANNA DAISY KOENIG

2. DATE OF DEATH 7-7-50

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Church Home - Hospital

\_\_\_\_\_

	Yrs.	Mos.	Days
a. Length of stay in Baltimore	4	1	8

5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
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F	W	Married
10A. USUAL OCCUPATION (Give kind of)		10B. KIND OF BUSINESS OR

work done during most of working life, even if retired) INDUSTRY  
 Housewife at home

13. FATHER'S NAME Waldman  
Harry Koenig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO
--	------------------------

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466
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4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

c. CITY OR TOWN (If outside corporate limits, give RURAL and give

Baltimore City

D. STREET ADDRESS (If rural, give location)  
5706 N 91st Ave St

8. DATE OF BIRTH	1875	9. AGE (In years last birthday)	If Under 1 Year Months; Days	If Under 24 Hours Hours; Min.
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1-15-1880	75			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF		

Baltimore

14. MOTHER'S MAIDEN NAME  
?

17. INFORMANT	ADDRESS
	Young

Parent

18.	585 X 1	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY			

**DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH**  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.	

(A) Pulmonary embolism 10 days

DUE TO

(B) Cholestyramine

DUE TO

90 1 1 1 1

Findings of Operation 20. AUTOPSY?

19A. DATE OF OPERATION 6-28-50	19B. MAJOR FINDINGS OF OPERATION autoclave	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
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21D. TIME (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
---------------------------------------	--	--	--	----------------------	--	----------------------------	--

INJURY

m. WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 6-28-50, to 7-7-50, that I last saw the

deceased alive on 7-7-53, 1953, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23A. SIGNATURE <u>[Signature]</u>	23B. ADDRESS <u>[Address]</u>	23C. DATE SIGNED <u>[Date]</u>
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M. D.		Church House - Hosp.		7-7-32
24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (city, town, or county)	(State)	

23A. BURIAL, CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county)	(State)
Burial	July 11, 1950	Oak Lawn Cemetery	Eastern Ave., Baltimore Md	

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <i>[Signature]</i>	25. FUNERAL DIRECTOR Schimunek Funeral Home	ADDRESS
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JUL 10 1950 *Washington, D.C.* 2601-5-5 E. Madison St. *General Home, Inc.*

VS 150 127a

**MEDICAL CERTIFICATION**

127a

CERTIFICATE OF DEATH

BALTIMORE, MARYLAND

REGISTERED

NAME

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6030  
Registered No. \_\_\_\_\_

364  
50 6030  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Joseph KOTRLA</b>			2. DATE OF DEATH <b>July 7, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3048 Boston St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>life</b>			D. STREET ADDRESS (If rural, give location) <b>3048 Boston St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>April 20, 1892</b>		9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired MACHINIST</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Monitor Control</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
13. FATHER'S NAME <b>John Kotrla</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217-20-7849</b>		
17. INFORMANT <b>Elizabeth Kotrla, wife,</b>			ADDRESS <b>3048 Boston St.</b>		

18. <b>322.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute alcoholism</b> DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION		

21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE <i>Stanley H. Durlacher</i> M.D.		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>July 8, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 10, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cem.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> 2601-3-5 E. Madison St.	

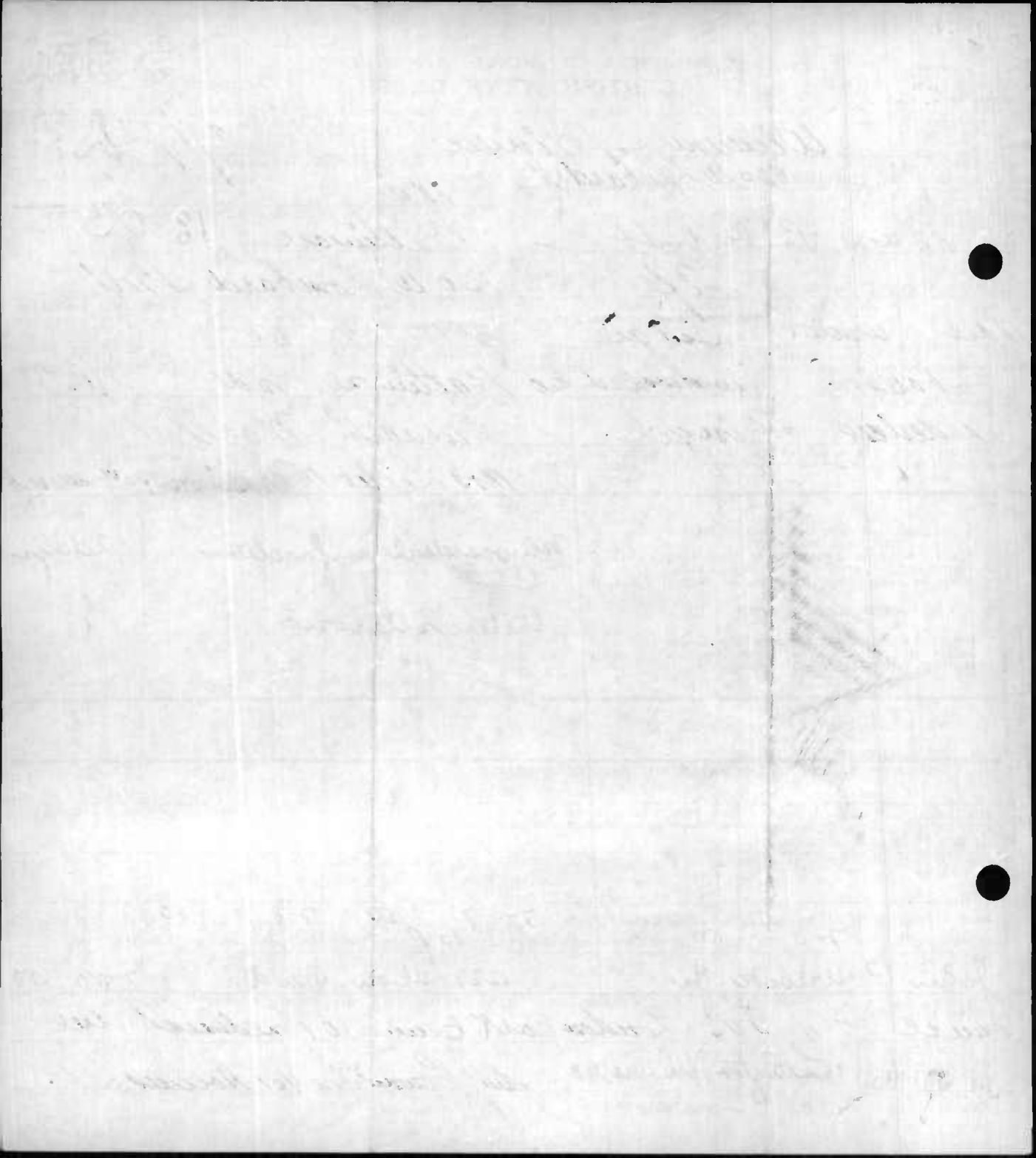
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524  
50 6031BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6031

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William J. Bingel</i>		2. DATE OF DEATH <i>7/8/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>830 W. Lombard St.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>830 W. Lombard St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>			
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>830 W. Lombard Street</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>Sept 1, 1884</i>	9. AGE (In years last birthday) <i>65</i>	10. Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Immigrant Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, MD</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>Fredrick Bingel</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Moeller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Lillie M. Massimer</i>	
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial infarction</i>		CAUSE OF DEATH (A) DUE TO <i>Anteroseclerosis</i> (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-7-1950</i> to <i>7-8-1950</i> , that I last saw the deceased alive on <i>7-8-1950</i> , and that death occurred at <i>10 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>John P. Urlock, Jr.</i>		23B. ADDRESS <i>1227 Wash. Blvd</i>		23C. DATE SIGNED <i>7-10-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>7/11/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>3801 Frederick Ave.</i>		25. FUNERAL DIRECTOR <i>John Cowan</i>		ADDRESS <i>Box 901 Hollis St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 10 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, MD</i>			





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6032

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Laura J. Williams</b>		2. DATE OF DEATH <b>July 7th, 1950</b>					
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____					
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1913 Division St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>					
c. Length of stay in Baltimore <b>13 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>1913 Division Street</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Mar. 25, 1862</b>				
		9. AGE (In years, last birthday) <b>88 yrs.</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>11 Under 1 Year</td> <td>11 Under 24 Hours</td> </tr> <tr> <td>Months: Days</td> <td>Hours: Min.</td> </tr> </table>	11 Under 1 Year	11 Under 24 Hours	Months: Days	Hours: Min.
11 Under 1 Year	11 Under 24 Hours						
Months: Days	Hours: Min.						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>					
13. FATHER'S NAME <b>Kohn W. Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Butler</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____					
		17. INFORMANT ADDRESS <b>Mrs. Helen Sanks 1913 Division St.</b>					

18. <b>260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TO <b>(A) arterial Insufficiency</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
<b>ANTECEDENT CAUSES</b>  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  DUE TO <b>(B) Hypertension</b> <b>arterio-sclerosis</b>		<b>?</b>
<b>II</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  DUE TO <b>(C) Diabetes</b>		<b>?</b>

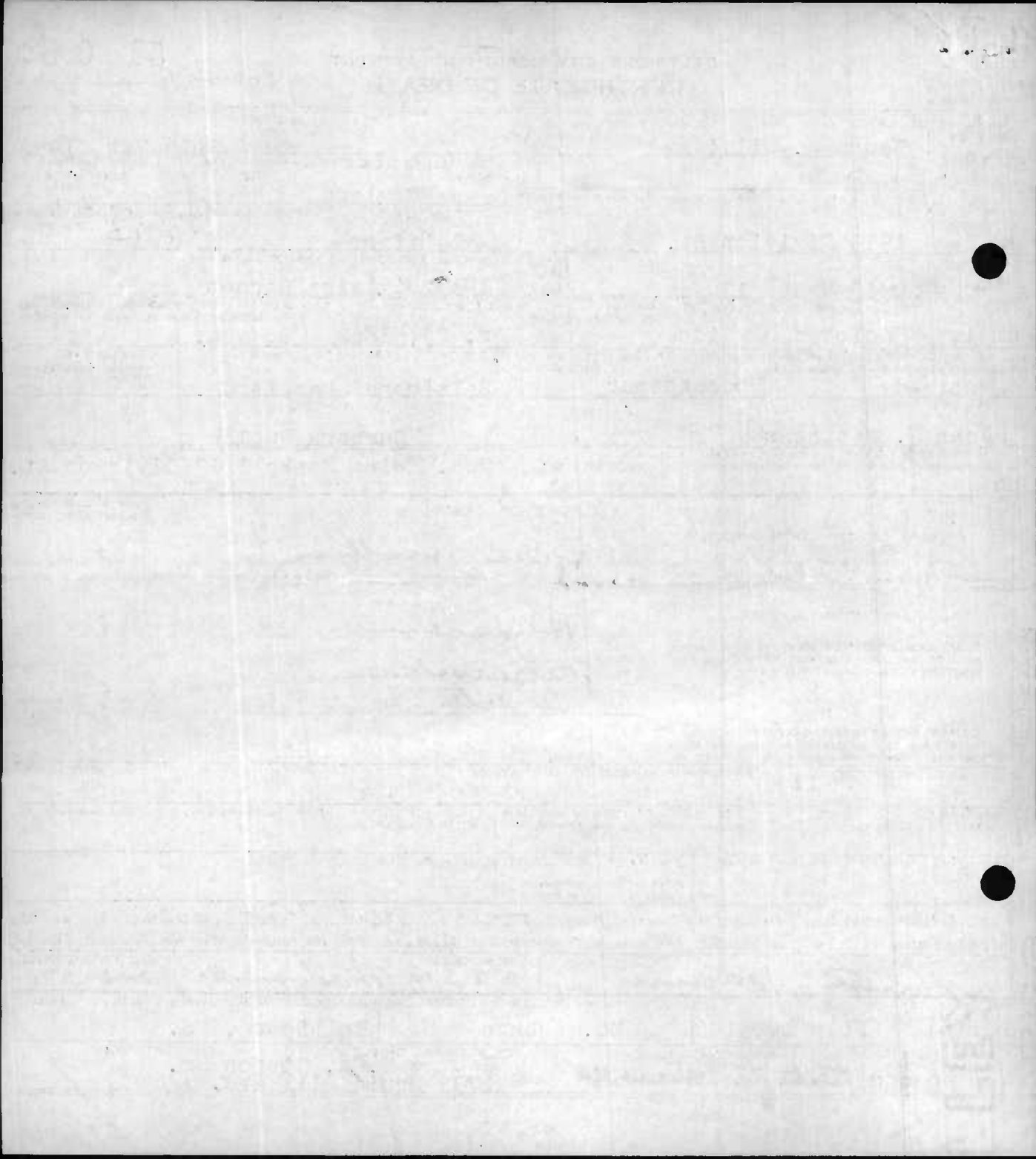
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **5-1-**, 19**50** to **7-7-**, 19**52** that I last saw the deceased alive on **7-7-**, 19**50**, and that death occurred at **9-4** a. m., from the causes and on the date stated above.

23A. SIGNATURE <b>Laura J. Williams</b>	M. D.	23B. ADDRESS <b>2224 Modern Ave</b>	23C. DATE SIGNED <b>7-8-50</b>
--	-------	--	-----------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 10, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
--	-----------------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>George T. A. Gibson Sr.</b>	ADDRESS <b>1735 Druid Hill Ave.</b>
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250  
6033

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6033  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Doris E. Jackson</b>		2. DATE OF DEATH <b>July 7-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Provident Hosp</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>1119 Calhoun St</b> B. COUNTY <b>Balto</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Provident Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1119 N. Calhoun St</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>9-14-1933</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Typist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>	9. AGE (In years last birthday) <b>16</b>
13. FATHER'S NAME <b>Herman Jackson</b>		11. BIRTHPLACE (State or foreign country) <b>Balto</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
16. SOCIAL SECURITY NO. <b>215-30-3576</b>		14. MOTHER'S MAIDEN NAME <b>Eva Gray</b>	
17. INFORMANT <b>Herman Jackson</b>		ADDRESS <b>1119 Calhoun St</b>	
18. <b>057.0</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Meningeal Cerebral Meningitis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>(B)</b> DUE TO <b>(C)</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO <b>(C)</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>At Work</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6/30</b> , 1950, to <b>7/7</b> , 1950 that I last saw the deceased alive on <b>7/7</b> , 1950, and that death occurred at <b>11:00</b> p.m., from the causes and on the date stated above.			
23A. SIGNATURE <b>E. Preston Grant</b>		23B. ADDRESS <b>601 W. Carrollton Ave</b>	23C. DATE SIGNED <b>7/10/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>July 11-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Balto.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>James A. Hayes</b>		ADDRESS <b>638 N. Fulton</b>	

MEDICAL CERTIFICATION

350877 3 4

*[Faint, illegible handwriting covering the upper and middle portions of the page. The text appears to be a series of lines, possibly a list or a narrative, but the characters are too light to transcribe accurately.]*

*[Faint handwriting at the bottom of the page, appearing to be a signature or a concluding line of text.]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6034

Registered No.

BIRTH NO. 3012608

1. NAME OF DECEASED  
(Type or Print)

*Baby "Boy" Slater*

2. DATE  
OF  
DEATH

6-22-00

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Md* B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 10-82*

D. STREET ADDRESS (If rural, give location)  
*917 Abbott Ct*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*SINGLE*

8. DATE OF BIRTH

*6/22/50*

9. AGE (in years last birthday)

10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*NONE*

10B. KIND OF BUSINESS OR INDUSTRY

*—*

11. BIRTHPLACE (State or foreign country)

*BALTO. Md*

12. CITIZEN OF WHAT COUNTRY?

*5*

13. FATHER'S NAME

*JOHN SLATER*

14. MOTHER'S MAIDEN NAME

*ALICE SMITH*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

*JOHNS HOPKINS HOSPITAL*

ADDRESS

18. *776 X I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

*Pre-maturity*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6-22*, 19*00* to *6-22*, 19*00* that I last saw the deceased alive on *6-22*, 19*00* and that death occurred at *230* m., from the causes and on the date stated above.

23A. SIGNATURE

*J. B. Shulbury Jr.*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*6/24/00*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wm. J. Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*UL 10 1950*

MEDICAL CERTIFICATION

July 1st 1900

WILLIAM SMITH

JOHN SLATER



152  
50 6035  
BIRTH NO. 50-12887BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6035  
Registered No.

1. NAME OF DECEASED (Type or Print)		BABY BOY EVANS		2. DATE OF DEATH June 28, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospital		A. STATE Maryland			
C. Length of stay in Baltimore U		B. COUNTY Baltimore			
5. SEX Male		6. COLOR OR RACE Colored		8. DATE OF BIRTH U	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) N		9. AGE (In years last birthday) 15-01		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY O		11. BIRTHPLACE (State or foreign country) K	
13. FATHER'S NAME W		14. MOTHER'S MAIDEN NAME O		12. CITIZEN OF WHAT COUNTRY? 5	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. N		17. INFORMANT N	
18. 762.5 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Neo-natal asphyxia due to immaturity

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (a. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R. Fisher		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED 5-29-50	

24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1950		REGISTRAR'S SIGNATURE L. Williams, M.D.		25. FUNERAL DIRECTOR C. Williams, M.D.		ADDRESS	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

2

RECEIVED  
JAN 1 1901

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6036  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WALENTY MAZINSKI</b>			2. DATE OF DEATH <b>June 14, 1950</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 2-03</b>		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) <b>708 S. Bethel Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>U</b>	8. DATE OF BIRTH <b>U</b>		9. AGE (In years last birthday) <b>- 65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>- A</b>	11. BIRTHPLACE (State or foreign country) <b>K</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>N</b>			14. MOTHER'S MAIDEN NAME <b>U</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>N</b>	17. INFORMANT ADDRESS <b>N</b>		

18. <b>420-1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Coronary artery sclerosis</b> DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> _____ DUE TO _____		
<b>(C)</b> _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21f. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23a. SIGNATURE <i>Stanley H. Durlacher</i>		23b. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23c. DATE SIGNED <b>June 15, 1950</b>	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY LOCAL REGISTRAR <b>10 1950</b>	REGISTRAR'S SIGNATURE <i>Washington Williams</i>	25. FUNERAL DIRECTOR <b>Funeral Home of Health</b>	ADDRESS
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THE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Page 1 of 1

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1915		New York City		New York City		Heart Disease		10:30 AM		Home		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Race		Color		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Teacher		Married		High School		Catholic		White		White		10/15/1960		10:30 AM		Home		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
10/15/1960		10:30 AM		Home		[Signature]		[Signature]		10/15/1960		10:30 AM		Home		[Signature]		[Signature]		10/15/1960	
Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death	
Heart Disease		10:30 AM		Home		[Signature]		[Signature]		Heart Disease		10:30 AM		Home		[Signature]		[Signature]		Heart Disease	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
10/15/1960		10:30 AM		Home		[Signature]		[Signature]		10/15/1960		10:30 AM		Home		[Signature]		[Signature]		10/15/1960	
Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Cause of Death	
Heart Disease		10:30 AM		Home		[Signature]		[Signature]		Heart Disease		10:30 AM		Home		[Signature]		[Signature]		Heart Disease	

000

50 6037

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 50 6037

1. NAME OF DECEASED  
(Type or Print)

Virgil J. Lee

2. DATE  
OF  
DEATH

7-8-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

Md.

B. COUNTY

D. D.

before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Gibson Island

D. STREET ADDRESS (If rural, give location)

5200

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

July 22, 1879

9. AGE (In years  
last birthday)

70

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mgr. (rtd)

10B. KIND OF BUSINESS OR  
INDUSTRY

Textile

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Harry M. Lee

14. MOTHER'S MAIDEN NAME

Sarah Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Margaret M. Lee

2933 St. Paul St.

18. 584X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Bronchopneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Intra-cranial hemorrhage

DUE TO

(C)

Central necrosis of liver

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

6-22-50

19B. MAJOR FINDINGS OF OPERATION

Acute suppurative cholecystitis; Cholelithiasis

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 July, 1950, to 8 July, 1950, that I last saw the  
deceased alive on 8 July, 1950, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

R. C. Spaulding, Jr.

M. D.

23B. ADDRESS

University Hospital

23C. DATE SIGNED

8 July 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

7/11/50

24C. NAME OF CEMETERY OR CREMATORY

Cross Creek

24D. LOCATION (City, town, or county)

Fayetteville, N. C.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 10 1950

T. L. Williams, M.D.

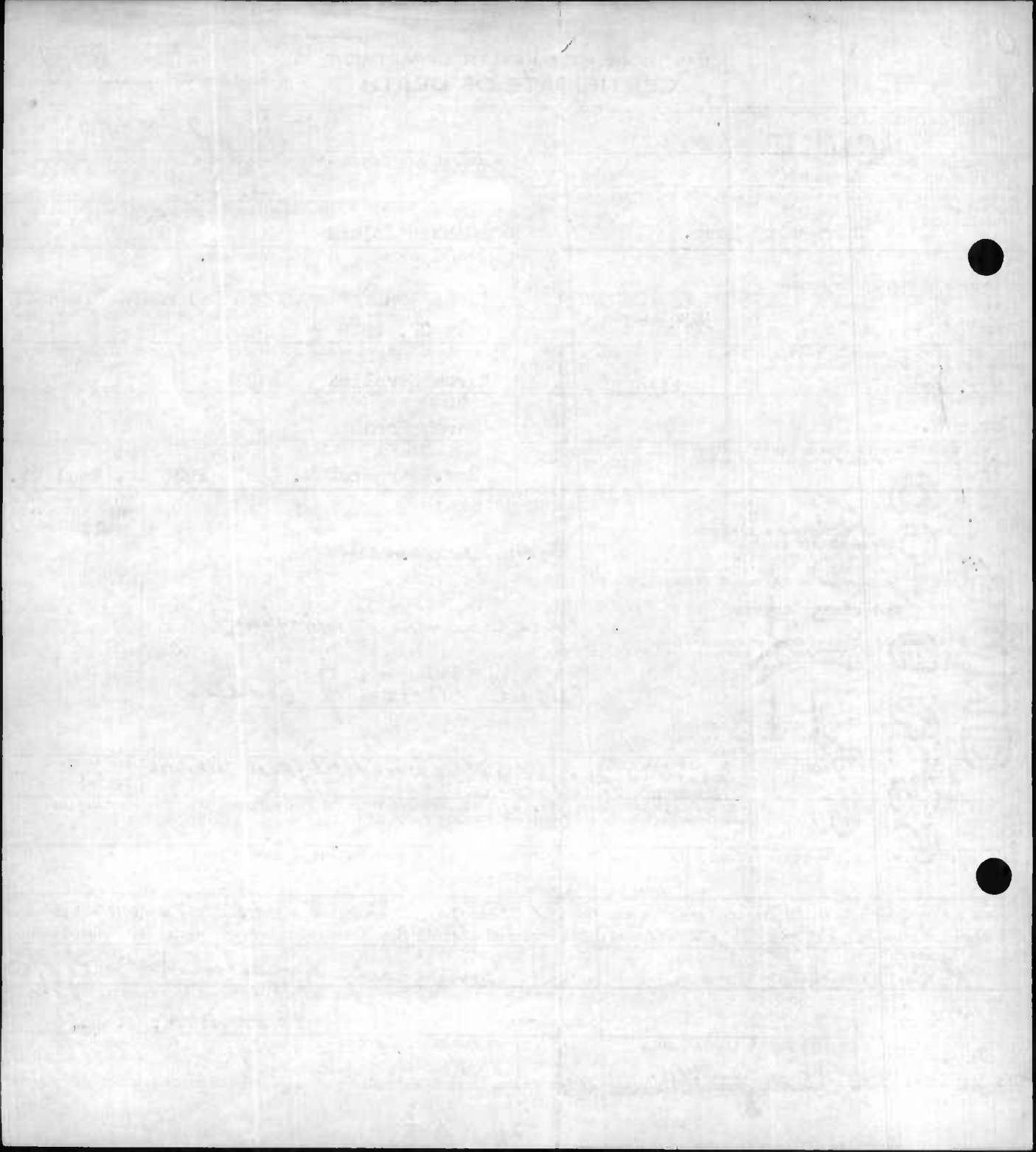
Wm. J. Lickner &amp; Sons, Baltimore, Md.

VS 150

2904E

126

MEDICAL CERTIFICATION





655  
50 6038BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6038  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>HARRY ANDREW FOREMAN</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1101 Elirno Way</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>26-06</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1101 Elirno Way</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Nov. 16, 1876</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>	9. AGE (In years; last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Taylor Foreman</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mrs. John W. Vaughan - 1924 Merritt Ave.</b>		D. ADDRESS <b>22, Md.</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO <b>HYPERTENSIVE C. V. DISEASE</b> DUE TO <b>BRONCHIAL ASTHMA</b>	INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>15 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 1947</b> to <b>July 8, 1950</b> that I last saw the deceased alive on <b>May 15, 1950</b> , and that death occurred at <b>6<sup>00</sup> A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>J. J. [Signature]</b>		23B. ADDRESS <b>6714 Holokid Ave</b>		23C. DATE SIGNED <b>July 8, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/12/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Wm. J. Williams</b>	
24G. FUNERAL DIRECTOR <b>Wm. J. Williams</b>		24H. ADDRESS <b>21m. J. Williams &amp; Sons, Balto</b>		24I. VS 150	

5235A 3 9

93) Md.

RECEIVED BY THE  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C.



356  
50 6039BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6039

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANNIE ELIZABETH WEIDNER		2. DATE OF DEATH July 7, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION 641 N. Bentalou St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-05			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 641 N. Bentalou St.			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Oct. 31, 1872	9. AGE (In years last birthday) 77	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Dalrymple Bouldin		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		14. MOTHER'S MAIDEN NAME Elizabeth Harris	
		17. INFORMANT Miss Helen Weidner		ADDRESS	
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Acute pulmonary congestion DUE TO Hypertensive and arteriosclerotic cardio-vascular disease (B) with chronic myocarditis and insufficiency (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1 July, 1950, to 7 July, 1950, that I last saw the deceased alive on 7 July, 1950, and that death occurred at 1 P. M., from the causes and on the date stated above.					
23A. SIGNATURE Emil H. Hemming Jr.		23B. ADDRESS 601 Winans Way		23C. DATE SIGNED 8 July 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/11/50		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	
		24D. LOCATION (City, town, or county) Balto., Md.			
DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1950		REGISTRAR'S SIGNATURE L. H. Williams, M.D.		25. FUNERAL DIRECTOR Wm. J. Dickner & Sons, Balto. Md.	



200

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6040  
Registered No.

BIRTH NO. 50 6040

1. NAME OF DECEASED  
(Type or Print)

Lee Edwards Cox

2. DATE  
OF  
DEATH

July 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Bryn Mbrg 2

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Va.

V-43

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Leesburg

D. STREET ADDRESS (If rural, give location)

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

4-4-98

9. AGE (In years  
last birthday)

52

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

13. FATHER'S NAME

Thomas Edwards

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Lily Rust

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT  
JOHNS HOPKINS HOSPITAL

ADDRESS

18. 175 x 1 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Generalized Carcinomatosis

4 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

Carcinoma of Ovary Left.

6 months

(C) .....

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONITION CAUSING IT.

none.

19A. DATE OF OPERATION

June 21-1950

19B. MAJOR FINDINGS OF OPERATION

Wide Spread Carcinoma Abdomen. Biopsy Done

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-20-1950 to 7-9-1950, that I last saw the  
deceased alive on 7-9-1950, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Robert P. O'Donnell

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7/9/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

7/10/50

24C. NAME OF CEMETERY OR CREMATORY

Union

24D. LOCATION (City, town, or county) (State)

Leesburg, Va.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wm. J. Williams, M.D.

25. FUNERAL DIRECTOR

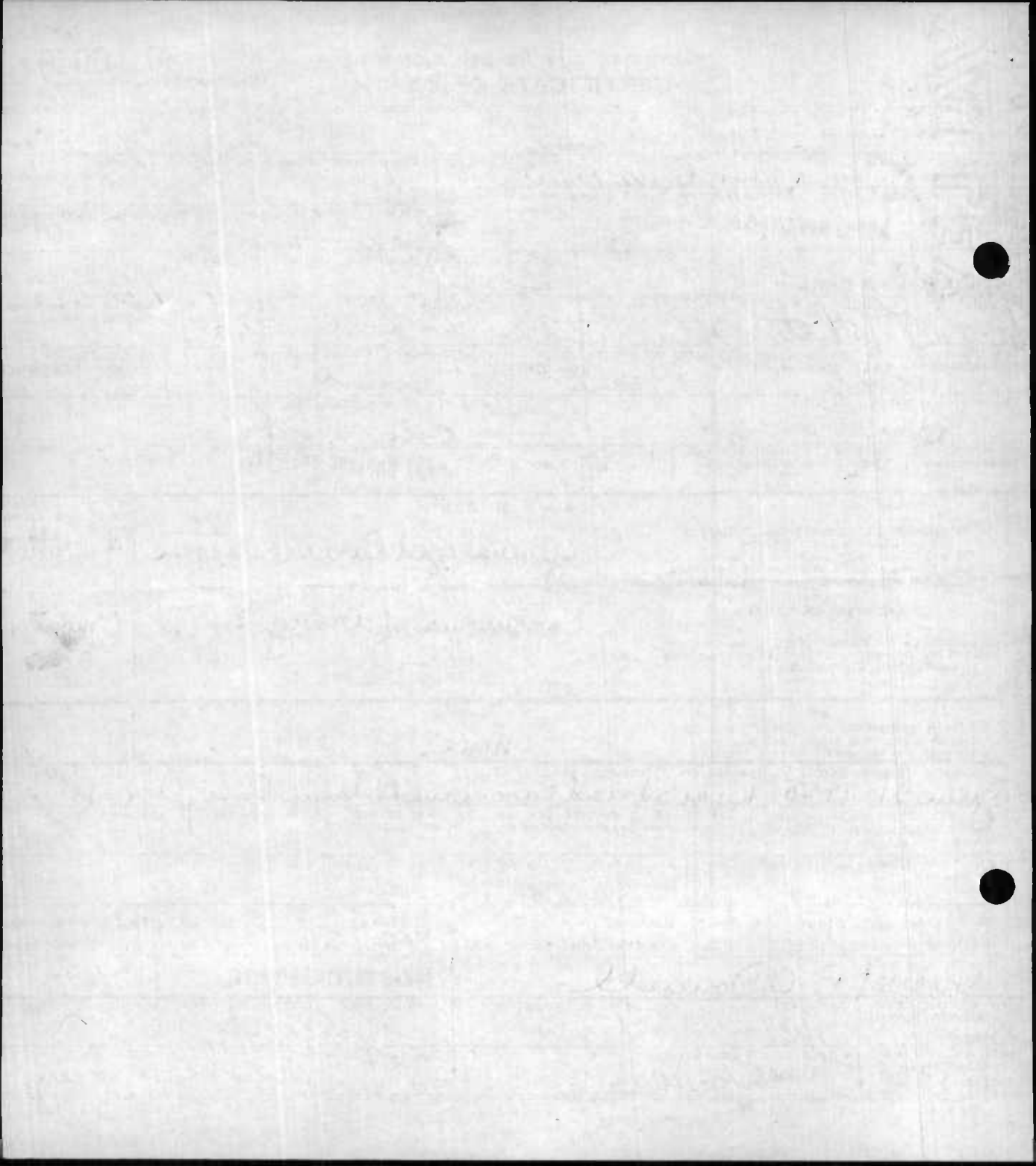
Wm. J. Tickner &amp; Sons, Balt.

ADDRESS

VS 150

49a

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6041**

**620**  
**6041**

1. NAME OF DECEASED (Type or Print) <b>Edward A Burris</b>		2. DATE OF DEATH <b>July 6 / 50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>434 N Luzerne</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>6-02</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balt</b>	
C. Length of stay in Baltimore <b>life</b>		D. STREET ADDRESS (If rural, give location) <b>434 N Luzerne Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Oct 28 / 1874</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auditor (Retired)</b>		9. AGE (in years, months, days) <b>75</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Consul Hon</b>		11. BIRTHPLACE (State or foreign country) <b>Balt</b>	
13. FATHER'S NAME <b>James N Burris</b>		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME <b>Eleanor Brown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Miss Sarah Burris 434 N Luzerne</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Degeneration</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cerebral Arteriosclerosis</b>		(B) <b>1 yrs.</b>	
(C) <b>Arteriosclerosis - generalized</b>		<b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 1945</b> to <b>July 6, 1950</b> , that I last saw the deceased alive on <b>July 5, 1950</b> and that death occurred at <b>12:15 pm.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>L. J. Rhines</b>		23B. ADDRESS <b>2623 E. Monument</b>	
23C. DATE SIGNED <b>7/7/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 10 / 50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Greenmont</b>		24D. LOCATION (City, town, or county) (State) <b>Balt</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <b>W. J. Williams, Jr.</b>	
25. FUNERAL DIRECTOR <b>Ulbert Funeral Home 2004 Ave</b>		ADDRESS	

MEDICAL CERTIFICATION

937

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mirrored and difficult to decipher.]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 6042

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WILLIAM H. ELLIS</b>		2. DATE OF DEATH <b>7/6/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>PROVIDENT HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
c. Length of stay in Baltimore <b>50yrs</b>		D. STREET ADDRESS (If rural, give location) <b>1601 MADISON AV.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2/8/1882</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>	10B. KIND OF BUSINESS OR INDUSTRY <b>MACHINERY</b>	9. AGE (In years last birthday) <b>68</b>	11. BIRTHPLACE (State or foreign country) <b>RICHMOND, VA.</b>
13. FATHER'S NAME <b>WM. ELLIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-07-5510</b>	
17. INFORMANT <b>ELIZA</b>		ADDRESS <b>1601 MADISON AV</b>	

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) <b>Pulmonary Edema</b> DUE TO		<b>3 days</b>
(B) <b>Cerebral Hemorrhage</b> DUE TO		<b>7 days</b>
(C) <b>Hypertensive C-V Renal Disease</b>		<b>?</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>6/29</b> , 19 <b>50</b> , to <b>7/6</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/6</b> , 19 <b>50</b> , and that death occurred at <b>3:30Pm.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>J. Preston Grant</b>		23B. ADDRESS <b>601 N. CARROLLTON AV</b>	23C. DATE SIGNED <b>7/10/50.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>7/10/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. Williams, Jr.</b>	25. FUNERAL DIRECTOR <b>Chas. H. Hooft</b>	ADDRESS <b>512 N. CARROLLTON AV</b>
--	---	---	--

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,  
January 1, 1901.

REPORT  
OF THE

ATTORNEY GENERAL,  
JAMES C. CLARK,

FOR THE YEAR 1900.

ALBANY:

WATKINS & COMPANY, PRINTERS,  
1901.

THE STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

IN SENATE,  
January 1, 1901.

REPORT  
OF THE

ATTORNEY GENERAL,  
JAMES C. CLARK,

FOR THE YEAR 1900.

ALBANY:

WATKINS & COMPANY, PRINTERS,  
1901.

380  
B.C. 50-13571  
6043

## BALTIMORE CITY HEALTH DEPARTMENT

50 6043

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)James Phillips  
Baby Boy Jett2. DATE  
OF  
DEATH

July 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1628 Clarkson St

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Infant

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR INDUSTRY

-

8. DATE OF BIRTH

7-3-50

9. AGE (In years last birthday)

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Balto. -

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Phillip C. Jett

14. MOTHER'S MAIDEN NAME

Ruth W. Jett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S NAME AND ADDRESS

Phillip C. Jett, JOHNS HOPKINS HOSPITAL, 1628 Clarkson St

18. 760.5

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intra cranial hemorrhage

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY  
YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from July 3, 1950 to July 9, 1950 that I last saw the deceased alive on July 9, 1950 and that death occurred at 12:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry M. Leidel

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

July 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 10, 1950

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

A. A. Co., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

JUL 10 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

A. Howard Evans 1400 S. Charles St.

ADDRESS

52. 9. 1. 1. 1.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6044**

BIRTH NO. **50 6044**

1. NAME OF DECEASED (Type or Print) <b>CLAUDIE ERNEST</b>			2. DATE OF DEATH <b>July 9, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR <b>US Marine Hospital</b> INSTITUTION <b>Wyman Pk. Drive &amp; 31st St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>12-06</b>		
5. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>100 W. 28th Street</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12/13/04</b>		9. AGE (In years last birthday) <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ala.</b>
13. FATHER'S NAME <b>Joseph Dickson</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no or unknown) <b>?</b>			16. SOCIAL SECURITY NO. <b>none</b>		
14. MOTHER'S MAIDEN NAME <b>Estella Baisden</b>			17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (A) DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  (C)	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>July 9, 1950</b> , to <b>July 9, 1950</b> , that I last saw the deceased alive on <b>DEAD ON ARRIVAL</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John L. Wilson, Medical Director</b> M. D.		23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>		23C. DATE SIGNED <b>7/10/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>7-12-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>	24D. LOCATION (City, town, or county) (State) <b>Smithland Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>	REGISTRAR'S SIGNATURE <b>William J. Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>J. William Fees, Inc. Co</b> <b>300-4 St. N.E.</b> <b>Washington D.C.</b> <b>937</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH

1970

10

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARITAL STATUS

PREVIOUS ILLNESS

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARITAL STATUS

PREVIOUS ILLNESS

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARITAL STATUS

PREVIOUS ILLNESS

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

420

50 6045

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6045

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

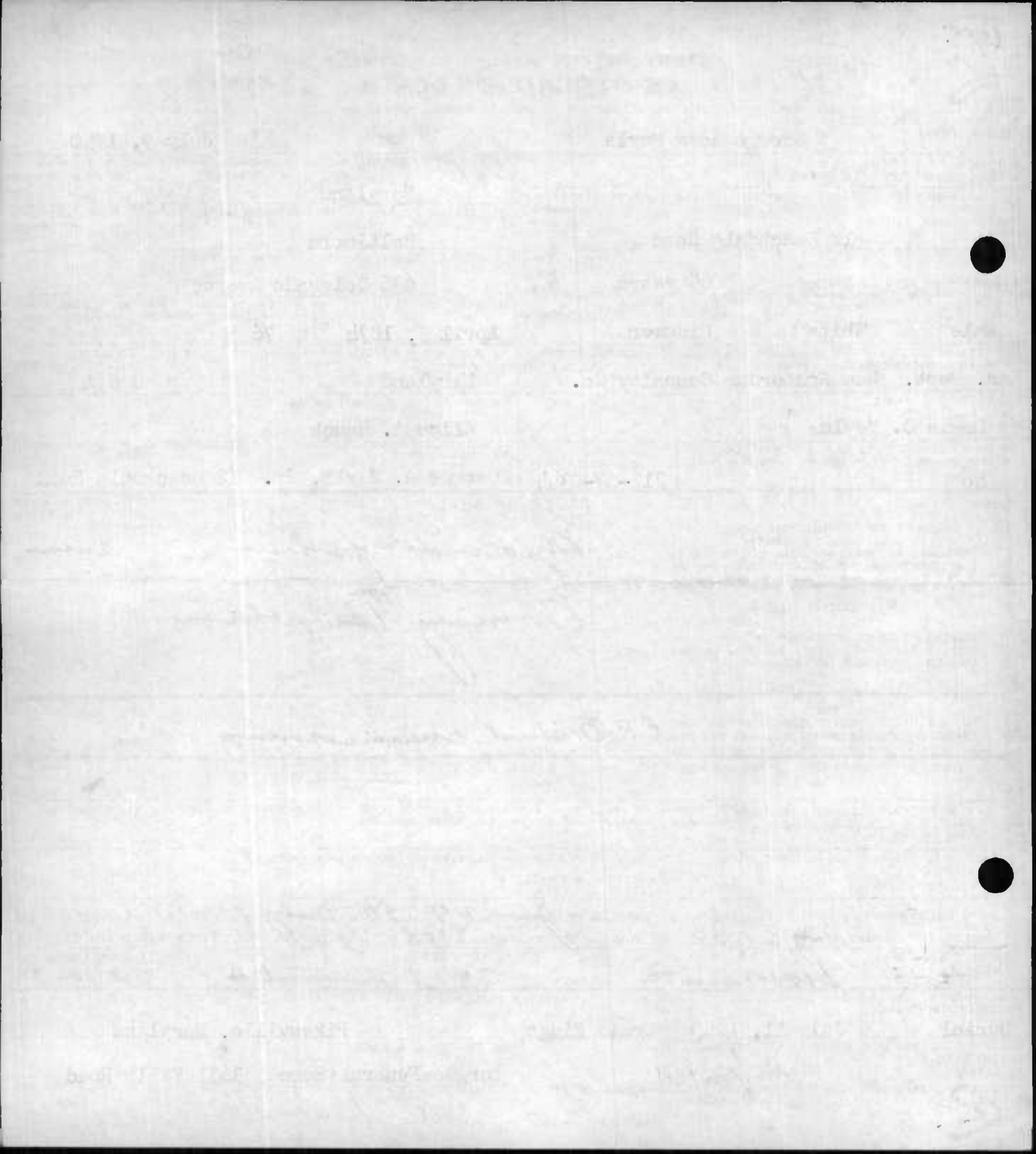
1. NAME OF DECEASED (Type or Print) <b>George Adam Meyls</b>		2. DATE OF DEATH <b>July 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-13</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>12 Beechdale Road</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>65 years</b>		D. STREET ADDRESS (If rural, give location) <b>636 Colorado Avenue</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>April 5, 1874</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Eng. Dept. New Amsterdam Casualty Co.</b>		9. AGE (In years last birthday) <b>76</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Lewis O. Meyls</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-0344</b>	17. INFORMANT ADDRESS <b>George A. Meyls, Jr. 12 Beechdale Road</b>

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> DUE TO <b>Coronary Thrombosis</b> DUE TO <b>C.C.O. about anterior coronary occlusion</b>	INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>2/1</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Jan 24, 1950</b> to <b>July 9, 1950</b> that I last saw the deceased alive on <b>July 8, 1950</b> , and that death occurred at <b>6:30 A. M.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>George A. Meyls, Jr.</b>	23B. ADDRESS <b>3427 Chantilly Ct A</b>	23C. DATE SIGNED <b>July 10-50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 11, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	24D. LOCATION (City, town or county) (State) <b>Pikesville, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>Burgess Funeral Home 3631 Falls Road</b>		

JUL 10 1950

Hance H. Burgess 94a



E-524  
50 6046BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6046  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John C. Englehardt</b>			2. DATE OF DEATH <b>July 8, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>511 W. 28th Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>511 W. 28th Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 15, 1895</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Corkran - Hill Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Englehardt</b>			12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>215-09-9738</b>		
14. MOTHER'S MAIDEN NAME <b>Mattie Mitten</b>			17. INFORMANT <b>Mrs. Alice A. Englehardt</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>1st World War</b>			ADDRESS <b>511 W. 28th St.</b>		

18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Coronary Occlusion 4 hrs.</b>	CAUSE OF DEATH (A) <b>Acute Coronary Occlusion 4 hrs.</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 8, 1950</b> to <b>July 8, 1950</b> , that I last saw the deceased alive on <b>July 8, 1950</b> , and that death occurred at <b>12:45 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Sol Smith</b>		23B. ADDRESS <b>12232 North Ave</b>		23C. DATE SIGNED <b>6/8/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 11, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co. Maryland</b>		24E. FUNERAL DIRECTOR <b>Burgee Funeral Home</b>		24F. ADDRESS <b>3631 Falls Road</b>	

JUL 10 1950

VS 150

68363

94a

Mr. Del Smith  
1223 E North Ave. Minn. 57230  
2426 Cutler Place Ma.



H-7580 6047

50 6047

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>MR. JESSE W. HAYES</b>			2. DATE OF DEATH <b>July 9, 1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Ind.</b> B. COUNTY <b>Baltimore</b>						
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 22 Dundalk</b>						
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>73 Dundalk Ave. 5300</b>						
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>27 Nov. 1868</b>		9. AGE (In years last birthday) <b>81</b>		10 Under 1 Year Months: Days	11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Retired for several years</b>			11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Hayes</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Brown</b>			17. INFORMANT <b>Margaret B. Hayes</b>			ADDRESS <b>73 Dundalk Ave. Balt. 22 Ind.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.						

18. **200.1**

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Lympho sarcoma****Unknown**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

**Arteriosclerotic Heart Disease**

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

**7-1-50****Diffuse tumor of abdomen -**YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from **6-26**, 19**50**, to **7-9**, 19**50** that I last saw the deceased alive on **7-9**, 19**50** and that death occurred at **1:10 p.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

**Francis H. Wan**

M. D.

**Union Memorial Hosp****7-9 50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

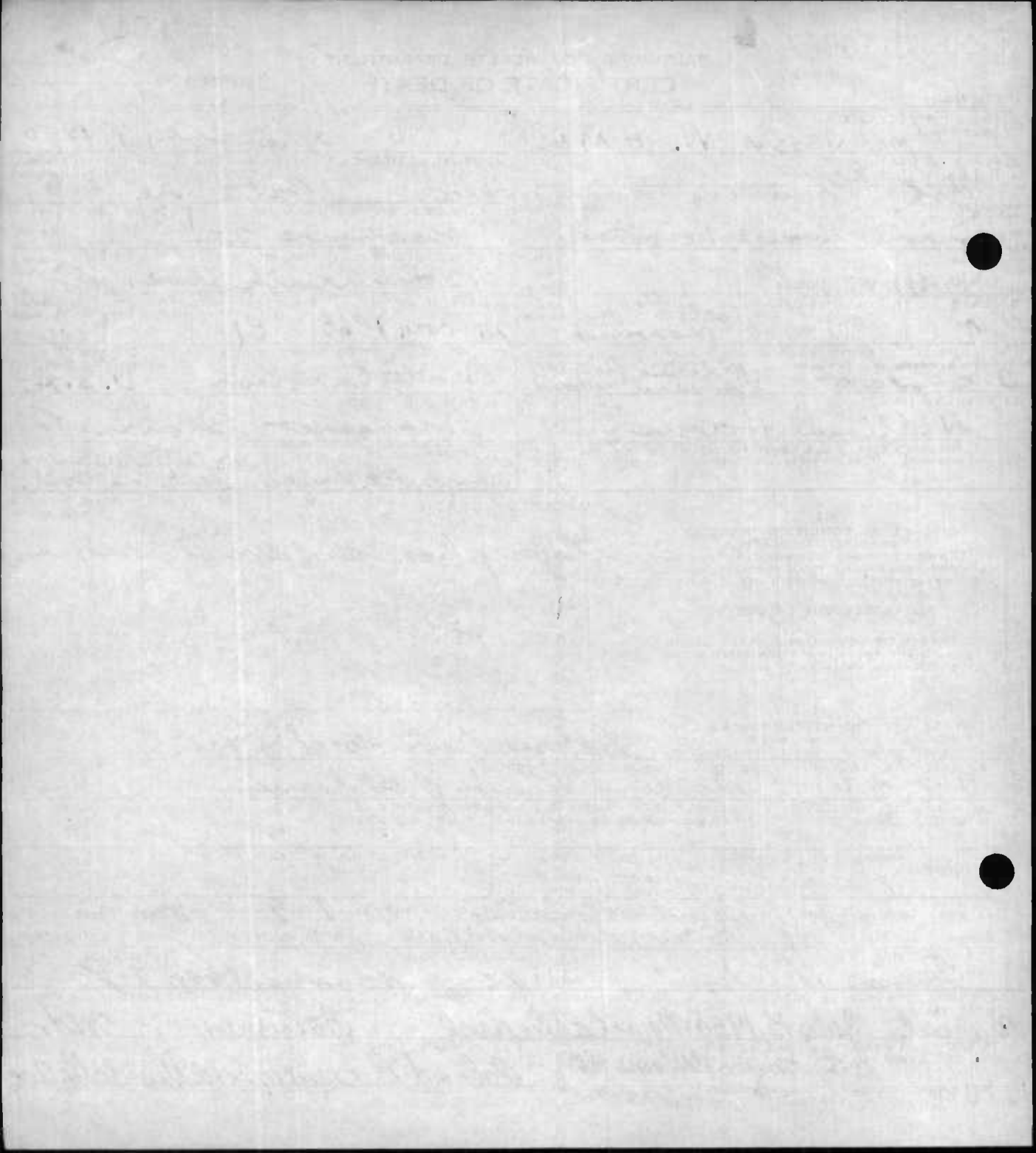
25. FUNERAL DIRECTOR

ADDRESS

**7-10-1950****Thurston Williams, M.D.****Roland L. Fisher, 2112 Dundalk Ave.**

55E

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print) *Ellen May Turner*

2. DATE OF DEATH *7/9/50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Maryland* B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
*Wm. W. W. Maryland*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore* *28-01*

c. Length of stay in Baltimore

D. STREET ADDRESS (If rural, give location)  
*3605 Woodbine Ave*

5. SEX *Female* 6. COLOR OR RACE *White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*Married*

8. DATE OF BIRTH *6-27-24-21-7674*

9. AGE (In years last birthday) *25* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Homemaker*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
*Baltimore, Md*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *John R. Fairbanks*

14. MOTHER'S MAIDEN NAME  
*Laura Black*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT *Richard A. Turner - 3605 Woodbine Ave*

18. *560.4* (over) *002X* CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cardiomegaly, Hypertensive Cardiomyopathy, congestive heart failure.* *yes.*

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Chronic Tuberculosis, Pulmonary, bilateral* *2 yrs.*

**II**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) *Rupture Lower third Esophagus.* *?*

19A. DATE OF OPERATION *7/8*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/8*, 19*50*, to *7/8*, 19*50*, that I last saw the deceased alive on *7/8*, 19*50*, and that death occurred at *6:20 A.m.*, from the causes and on the date stated above.

23A. SIGNATURE *Mark S. Hall, Jr.*

23B. ADDRESS *Worcester Mass.*

23C. DATE SIGNED *7/9/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE *July 11, 1950*

24C. NAME OF CEMETERY OR CREMATORY *Loudon Park Cemetery*

24D. LOCATION (City, town, or county) (State)  
*Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR *10/10/50*

REGISTRAR'S SIGNATURE *[Signature]*

25. FUNERAL DIRECTOR *E. M. L. Lamoreau*

ADDRESS *4510 Liberty Heights Ave.*

Request the doctor to rearrange  
the order of the causes as specified  
on the medical certification so as  
to make clear his opinion of  
the underlying cause of death.

" <sup>underlying or</sup>  
~~immediate~~ cause : prob. rupture of esophagus  
tuberculosis : controlled at time of death  
other significant pathology : bad cardiac disease. "

See Document File 50-6149  
8-24-50

Es.

22  
50 6049BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6049  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>CALVIN CHARLES PARKES</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: a. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>US Marine Hospital Wyman Pk. Drive &amp; 31st St.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>?</b>		d. STREET ADDRESS (If rural, give location) <b>5306 York Road</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3/17/89</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired tool maker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Records- US Marine Hospital, Balto, Md.</b>		ADDRESS	

18. <b>420.5 527.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Emphysema, chronic with spontaneous pneumothorax</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary sclerosis severe and myocardial infarction, old</b>		
19a. DATE OF OPERATION <b>7/8/50</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **July 2**, 19**50**, to **July 8**, 19**50**, that I last saw the deceased alive on **July 8**, 19**50**, and that death occurred at **4:05 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE **W. J. Duley** M. D. 23b. ADDRESS **US Marine Hospital, Balto, Md.** 23c. DATE SIGNED **7/8/50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **July 11, 1950** 24c. NAME OF CEMETERY OR CREMATORY **Balto National** 24d. LOCATION (City, town, or county) (State) **Fredrick Rd. Md.**

DATE RECEIVED BY LOCAL REGISTRAR **Huntington Williams, Jr.** REGISTRAR'S SIGNATURE **Ernest E. Donovan** 25. FUNERAL DIRECTOR **3518 Roland Ave** ADDRESS

JUL 10 1950

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50 6050BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6050  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Margaret A. Mallon</b>		2. DATE OF DEATH <b>7-8-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>33 S. Highland Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Md. 26-08</b>			
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>33 S. Highland Ave</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>4-14-83</b>	9. AGE (In years last birthday) <b>67</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John O'Connor</b>		14. MOTHER'S MAIDEN NAME <b>Anna ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wm. Mallon</b>	
				ADDRESS <b>33 S. Highland Avenue</b>	
18. <b>422.1</b>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Arteriosclerotic Cardiovascular Disease</b>			
ANTECEDENT CAUSES		DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Arteriosclerosis Generalized</b>			
		DUE TO			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Cerebral Arteriosclerosis.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 1, 1943</b> , to <b>July 8, 1950</b> , that I last saw the deceased alive on <b>7-8-50</b> , 19 <b>50</b> , and that death occurred at <b>1:30 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John Costantini</b>		23B. ADDRESS <b>234 S. Conkling St.</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-12-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 10 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler, Inc, 403 S. Wolfe Street</b>	
				ADDRESS	

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1. NAME OF DECEASED (Type or Print)		Edward L. Tully		2. DATE OF DEATH		7-8-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland				Balto.			
B. FULL NAME OF HOSPITAL OR INSTITUTION				623 S. Milton Ave.			
c. Length of stay in Baltimore				Life		Yrs. Mos. Days	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
M.		W.		Married		12-18-80	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Transfer Bus.				Self			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Tully				Antionette Bandzwolek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
✓		✓		Catherine Tully- 623 S. Milton Ave			

18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO		Coronary Thrombosis		-	
(B) DUE TO		Arterio-sclerosis,			
(C) DUE TO		generalized		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1948, 19 to July 8, 1950, that I last saw the deceased alive on June 5, 1950, and that death occurred at 9.05A.m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Signature R. Nowak		M. D. 408 S. Patt. Ph. An.		7-10-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7-11-50		St. Stanislaus	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
JUL 10 1950		T. W. Williams, M.D.		Lilly & Zeiler, Inc 403 S. Wolfe Street	

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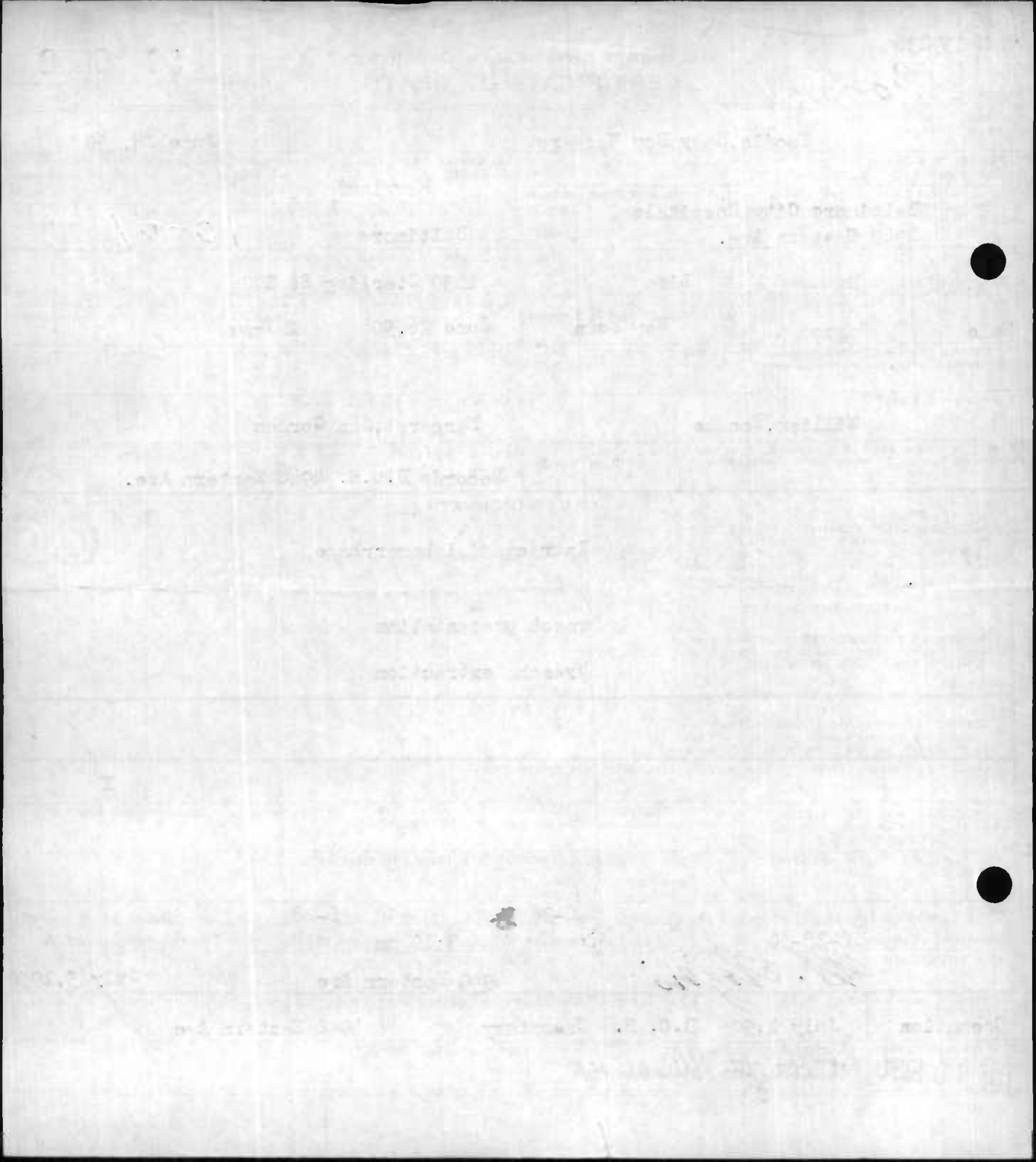
50 6052

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6052

BIRTH NO. 50-12754		2. DATE OF DEATH June 28, 50	
1. NAME OF DECEASED (Type or Print) Toodle, Baby Boy Margaret		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY	
3. PLACE OF DEATH: A. Baltimore City, Maryland		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.		D. STREET ADDRESS (If rural, give location) 1030 Sterling St Z 2	
c. Length of stay in Baltimore Life		Yrs. Mos. Days	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) New Born	8. DATE OF BIRTH June 26, 50
9. AGE (in years last birthday) 2 Days		If Under 1 Year Months: Days Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William, Toodle		14. MOTHER'S MAIDEN NAME Margaret, Ann Gordon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records B.C.H.		ADDRESS 4940 Eastern Ave.	
18. 760.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Intracranial hemorrhage DUE TO ANTECEDENT CAUSES (B) Breech presentation DUE TO (C) Breech extraction II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-26, 1950, to 6-28, 1950 that I last saw the deceased alive on 6-28-50, 1950 and that death occurred at 3:10 pm from the causes and on the date stated above.			
23A. SIGNATURE [Signature]		23B. ADDRESS 4940 Eastern Ave	
M. D.		23C. DATE SIGNED July 5, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24B. DATE July 1, 50	
24C. NAME OF CEMETERY OR CREMATORY B.C. H. Crematory		24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave	
DATE RECEIVED BY LOCAL REGISTRAR JUL 10 1950		REGISTRAR'S SIGNATURE [Signature]	
25. FUNERAL DIRECTOR		ADDRESS	

MEDICAL CERTIFICATION





6053

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6053

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emma T. Meyer

2. DATE  
OF  
DEATH

July 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2840 Cold Spring La.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2840 Cold Spring Lane.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland, B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore, Md. 15-13

D. STREET ADDRESS (If rural, give location)

2840 W. Cold Spring Lane.

C. Length of stay in Baltimore

6 months  
18 daysYrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Nov. 25, 1871

9. AGE (In years;  
last birthday)

78

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

William A. Capes

14. MOTHER'S MAIDEN NAME

Mary Crandall

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.  
None

17. INFORMANT 2840 ADDRESS

Mrs. Ida Herman, Cold Spring La.

18. 153X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Generalized Abdominal Carcinomatosis

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

3 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Carcinoma of Sigmoid

DUE TO

3 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

Generalized Atherosclerosis

10 yrs.

19A. DATE OF OPERATION

April 6, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Sigmoid.

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 4, 1949, to July 8, 1950, that I last saw the deceased alive on July 5, 1950, and that death occurred at 2 p.m., from the causes and on the date stated above.

23A. SIGNATURE

H. W. Prince

M. D.

23B. ADDRESS

Lorraine Cemetery

23C. DATE SIGNED

July 8, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 11/50

24C. NAME OF CEMETERY OR CREMATORY

Lorraine Cemetery Woodlawn, Baltimore, Md.

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ellis S. White, 2840 Cold Spring La.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

400  
50 6054BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6054

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Charles F. Heik</i>			2. DATE OF DEATH <i>July 7, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>22 S. Athol Ave.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-085</i>		
c. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>612. Northcan Parkway</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>6/2/1880</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inv &amp; Real Estate Agt. -</i>			11. BIRTHPLACE (State or foreign country) <i>Baltimore - Md.</i>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		
13. FATHER'S NAME <i>HENRY HEIK</i>			14. MOTHER'S MAIDEN NAME <i>Caroline Roeth</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>-</i>			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Elizabeth J. Heik</i>			ADDRESS <i>Same</i>		

18. <i>420.1</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>Chronic Myocarditis</i>	
ANTECEDENT CAUSES	(B) <i>Acute Coronary Disease</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan. 17, 1947</i> to <i>July 7, 1950</i> , that I last saw the deceased alive on <i>July 5, 1950</i> , and that death occurred at <i>10 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert C. Blake</i>		23B. ADDRESS <i>Md. Auto Bldg.</i>		23C. DATE SIGNED <i>7-10-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>July 11, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem. Balto. Md.</i>	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR <i>Huntington Williams, M.D.</i>		ADDRESS <i>1310 Eastwood Rd.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 11 1950</i>					

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 6055

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) William M. Bowen

2. DATE OF DEATH July - 9 - 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION  
2736 Kinsey Ave

C. Length of stay in Baltimore life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland  
B. COUNTY Baltimore  
C. CITY OR TOWN Baltimore  
D. STREET ADDRESS (If rural, give location) 2736 Kinsey Ave.

5. SEX Male

6. COLOR OR RACE white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Aug 5 - 1867

9. AGE (In years last birthday) 82

10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Telegraph Operator

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin Bowen

14. MOTHER'S MAIDEN NAME Priscilla Wood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Edna S. Bowen

ADDRESS - Same

18. 4/20.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
Coronary Thrombosis

INTERVAL BETWEEN ONSET AND DEATH May 1. 50

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
Chronic Nephritis

2. yrs

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1950 to July 8, 1950, that I last saw the deceased alive on July 8, 1950 and that death occurred at 10:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE Chas W. Cahn

23B. ADDRESS 2145 W Balto St

23C. DATE SIGNED 7/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE July - 11/50

24C. NAME OF CEMETERY OR CREMATORY Loudon Park

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1950

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR J. B. Shippert & Son

ADDRESS 1800 Eutaw Pl. 17

VS 150

500 50 6055

1312

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6056**

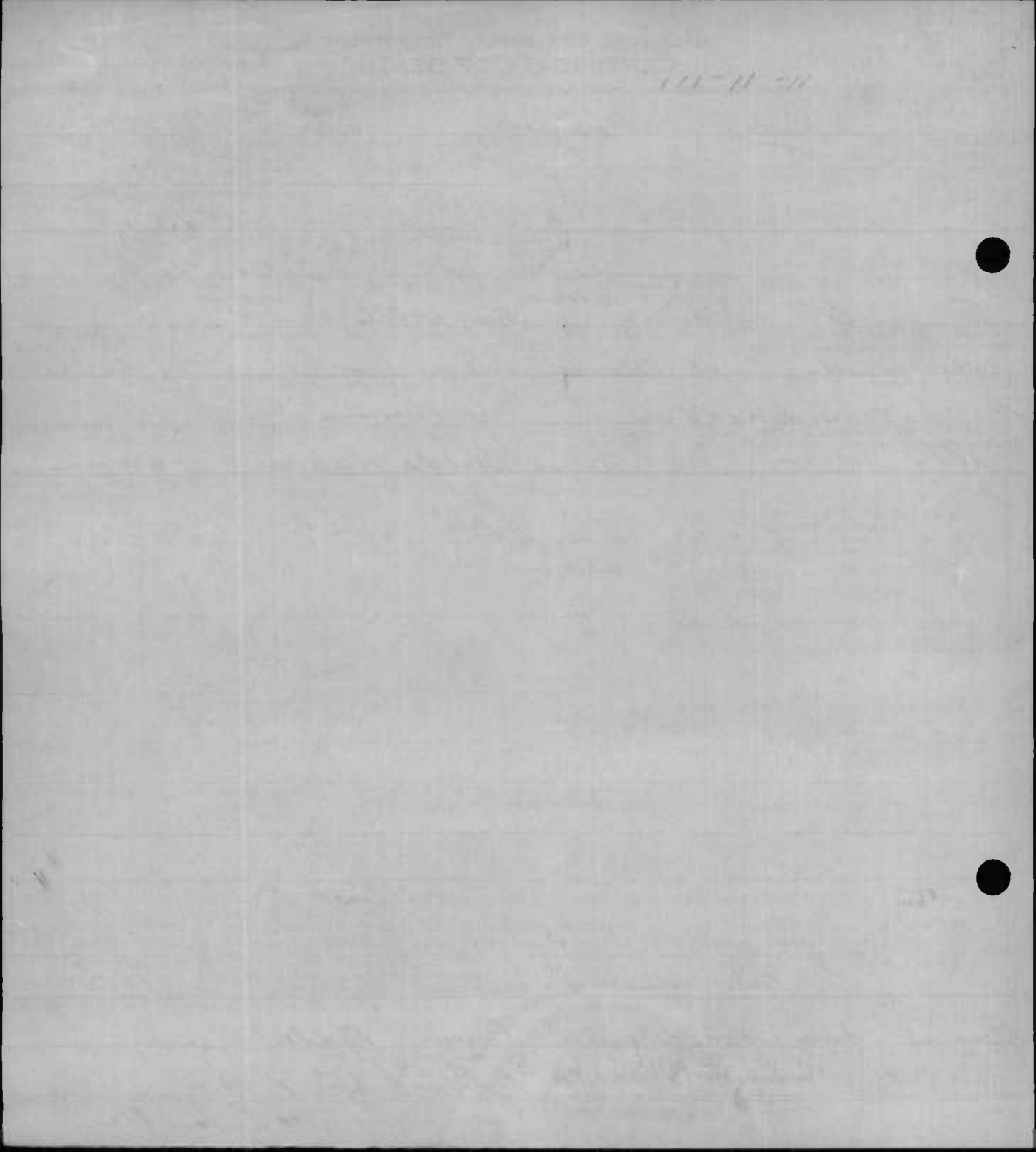
1. NAME OF DECEASED (Type or Print) <u>Katherine Kramer</u>		2. DATE OF DEATH <u>2/8/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>20-03</u>	
a. FULL NAME OF HOSPITAL OR INSTITUTION <u>2014 Ramsay St</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore Md</u>	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <u>2014 Ramsay St</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 6-1961</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	9. AGE (In years last birthday) <u>88</u>
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>August Schneider</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hilda Huber</u>		ADDRESS <u>- Same</u>	

18. <u>4 yr 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Antenatal disease</u>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(B) DUE TO		
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <u>D. P. J. Schirmer</u>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <u>2/9/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>July 12/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Western Cove</u>	24D. LOCATION (City, town or county) (State) <u>Balto Md</u>
25. FUNERAL DIRECTOR <u>Huntington Williams, M.D.</u>		ADDRESS <u>F. B. Shippert &amp; Son 937</u>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6057**

**50 6057**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Charles B. Keller "Charles B. Keller"</b>		2. DATE OF DEATH <b>7-8-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>West Baltimore General Hospital Baltimore, Md. 20-07</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
C. Length of stay in Baltimore <b>5 1/2</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>344 N. Nelson St. #29.</b>	

5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>APR. 21-1898</b>	9. AGE (In years last birthday) <b>62</b>	10 Under 1 Year Months: Days	11 Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watch maker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia Pa</b>	
13. FATHER'S NAME <b>Bernard Keller</b>			14. MOTHER'S MAIDEN NAME <b>Ida C. Jeffries</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>215-01-2954</b>	17. INFORMANT <b>MARY B. Keller - Sister</b>	ADDRESS
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18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) <b>Coronary Infarction</b>		DUE TO	<b>3 hrs 23 min</b>
(B) <b>Coronary Thrombosis</b>		DUE TO	
(C)		DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **on 7-8-1950** to **1950**, that I last saw the deceased alive on **7-8-1950**, and that death occurred at **8:25** m., from the causes and on the date stated above.

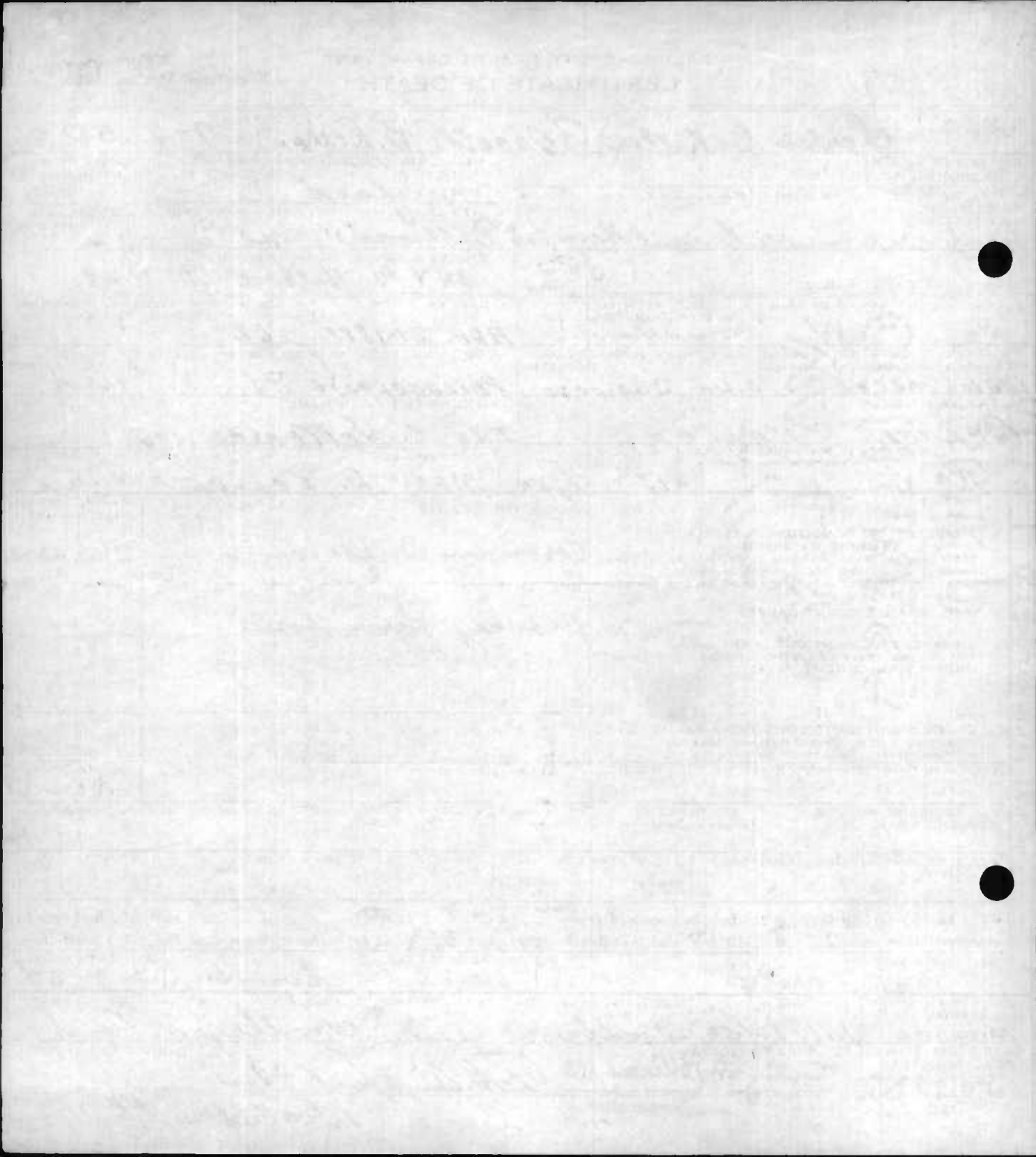
23A. SIGNATURE <b>M.S. Daly</b>	23B. ADDRESS <b>West Balto. Gen. Hosp</b>	23C. DATE SIGNED <b>7-8-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 12/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn Md</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>H. B. Whippert &amp; Son</b>	ADDRESS
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**VS 150**  
**29084 6057 1300 Eutan Pl '7 94a**

MEDICAL CERTIFICATION



620  
209659BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6058  
Registered No.

BIRTH NO. 6058 50-11512

1. NAME OF DECEASED (Type or Print) Baby Burke		2. DATE OF DEATH June 12, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 15-81	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1606 Booker Court	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH June 10, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 2
13. FATHER'S NAME William Burke		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Gwendolyn Pride	
17. INFORMANT Hospital Records		ADDRESS	

18. 773.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) Massive Hemorrhage into lungs DUE TO  (B) Anoxemia DUE TO  (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION 7	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from June 10, 1950, to June 12, 1950, that I last saw the deceased alive on June 12, 1950, and that death occurred at 2:05 A. M., from the causes and on the date stated above.		
23A. SIGNATURE L. E. Stowers, Jr.	23B. ADDRESS 601 N. Broadway	23C. DATE SIGNED June 12, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY Hospital Disposal	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1950	REGISTRAR'S SIGNATURE Ruthington Williams, M.D.	25. FUNERAL DIRECTOR	ADDRESS





642  
520  
50 6059BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6059  
Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>MICHAEL KARAHINS (King)</b>			2. DATE OF DEATH <b>July 7 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>13-04</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Windsor Rest home</b>			D. STREET ADDRESS (If rural, give location) <b>2706 Muchen Toroly Ter.</b>			E. DATE OF BIRTH <b>Oct 15 1868</b>		
c. Length of stay in Baltimore <b>62 yr</b>			F. AGE (In years last birthday) <b>81 82</b>			G. Under 1 Year Months: Days: Hours: Min.		
5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>			7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Clot &amp; mfg</b>			11. BIRTHPLACE (State or foreign country) <b>Lith</b>		
13. FATHER'S NAME <b>Joseph Karahins</b>			16. SOCIAL SECURITY NO. <b>no</b>			17. INFORMANT <b>Victor King</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>			16. SOCIAL SECURITY NO. <b>no</b>			17. INFORMANT <b>Victor King</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Cardiac Failure</b>			CAUSE OF DEATH (A) DUE TO <b>Generalized Arteriosclerosis</b> (B) DUE TO <b>Cardiovascular Disease</b> (C) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>7/2</b> , 19 <b>50</b> , to <b>7/7</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/7</b> , 19 <b>50</b> and that death occurred at <b>2:4</b> a.m., from the causes and on the date stated above.			23A. SIGNATURE <b>Joseph Karahins</b>			23B. ADDRESS <b>675 Washington Blvd</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>July 11-1950</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cn</b>		
24D. LOCATION (City, town, or county) (State) <b>Belair Rd Md</b>			24E. FUNERAL DIRECTOR <b>Joseph Karahins</b>			24F. ADDRESS <b>602 Wood</b>		

Cat 4575

212

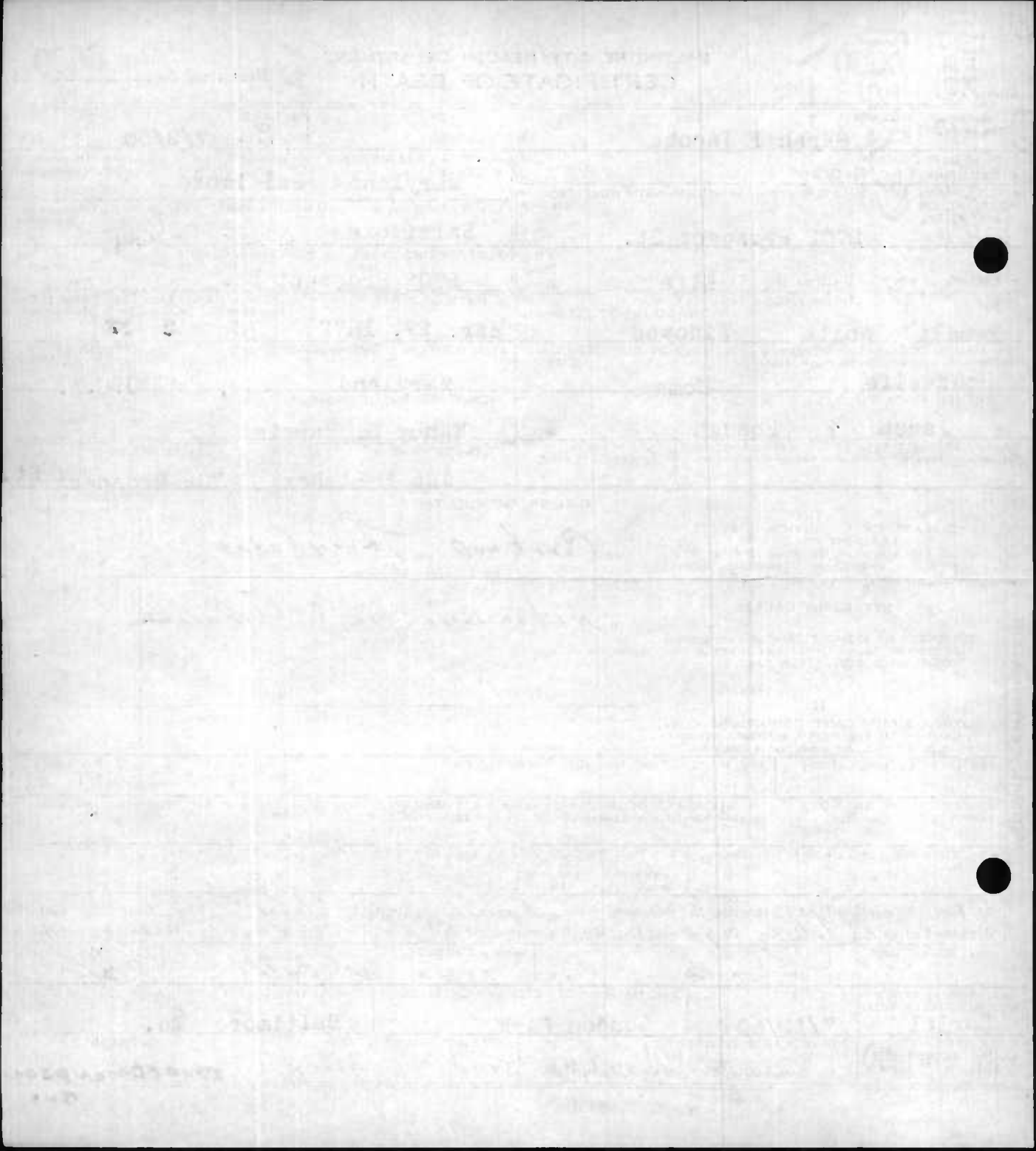
50 6060

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6060  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Sarah I Jacobs</b>		2. DATE OF DEATH <b>7/9/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> P. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2702 Prospect St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>16-06</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>2702 Prospect St.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mar. 27, 1872</b>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Jacob F Ebaugh</b>		14. MOTHER'S MAIDEN NAME <b>Nancy S. Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Ida E Fisher 2702 Prospect St.</b>	
17. INFORMANT <b>Ida E Fisher</b>		ADDRESS <b>2702 Prospect St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pericardial Thrombosis</b>		CAUSE OF DEATH <b>Pericardial Thrombosis</b>	
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Anterior dentritic C. V. disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>April 1946</b> to <b>July 1950</b> , that I last saw the deceased alive on <b>July 5, 1950</b> , and that death occurred at <b>5:12 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>P. P. Williams</b>		23B. ADDRESS <b>1845 W. B. 1st</b>	
23C. DATE SIGNED <b>7/9/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/12/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		25. FUNERAL DIRECTOR <b>JOHN T. STANSBURY</b>	
REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>		ADDRESS <b>2700 EDMONDSON</b>	

MEDICAL CERTIFICATION



600  
50 6061BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6061  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WALTER STAFFORD CARRE SR.</b>		2. DATE OF DEATH <b>July 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1527 Ralworth Road</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 18 9-02</b>	
C. Length of stay in Baltimore <b>50 years</b>		D. STREET ADDRESS (If rural, give location) <b>1527 Ralworth Road</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Mar. 16, 1873</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher-Storekeeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired 10 Yrs.</b>	9. AGE (In years last birthday) <b>77</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wm. A. Carre</b>		14. MOTHER'S MAIDEN NAME <b>Maude Alice ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-8760</b>	
17. INFORMANT <b>Mrs. Thomas B. Streett (Daughter)</b>		ADDRESS <b>1527 Ralworth Road.</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> DUE TO <b>Hyperbromi Cardio Vascular disease</b>	INTERVAL BETWEEN ONSET AND DEATH <b>3 mi</b> <b>5 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Injury</b>	
22. I hereby certify that I attended the deceased from <b>July 8, 1950</b> , to <b>July 8, 1950</b> , that I last saw the deceased alive on <b>July 8, 1950</b> and that death occurred <b>July 8, 1950</b> at <b>8 AM</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John J. Rinzier</b>		23B. ADDRESS <b>2700 Hanford Rd</b>		23C. DATE SIGNED <b>July 10, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jul. 11, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md.</b>		24E. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>		24F. ADDRESS <b>Baltimore Md.</b>	

United States  
Department of the Interior  
Bureau of Land Management

July 10, 1964  
A. R.

July 10, 1964  
B. R.



500  
LC  
78293 50 6062  
BIRTH NO. 50 6062

CLAIMED FOR CITY HOSP. 7/19/50.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6062

1. NAME OF DECEASED (Type or Print) Daniel Donohue		2. DATE OF DEATH July 4, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-05	
c. Length of stay in Baltimore Life Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1525 E. North Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 27, 1880
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 69
13. FATHER'S NAME Sam Donohue		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO. none		14. MOTHER'S MAIDEN NAME Bertha Frank	
18. 501X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Furulent Bronchitis And Broncho- Pneumonia, Bilateral DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease.		17. INFORMANT Records* Baltimore City Hospitals	
19A. DATE OF OPERATION 7/11/50		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from Nov. 30, 1942, to July 4, 1950, that I last saw the deceased alive on July 4, 1950, and that death occurred at 2:05 PM., from the causes and on the date stated above.	
23A. SIGNATURE R. B. Cohen		23B. ADDRESS 4940 Eastern Avenue	
23C. DATE SIGNED 7-10-50		24A. BURIAL, CREMATION, REMOVAL (Specify) burial	
24B. DATE 7/11/50		24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. Baltimore, Md.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 11 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
VS 150		93D	

11-1256

540

50 6063

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6063

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HOWARD WILLIAM TENLEY

2. DATE  
OF  
DEATH

July 8, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1633 Normal Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1633 Normal Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Dec. 1, 1888

9. AGE (In years  
last birthday)

61

11 Under 1 Year  
Months Days11 Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Foreman, retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Cigar Factory

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Howard Tenley

14. MOTHER'S MAIDEN NAME

Agnes Bauer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.  
215-03-423017. INFORMANT ADDRESS  
Herbert A. Tenley, 8538 Water Oak Ave.

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma of Lung

INTERVAL BETWEEN  
ONSET AND DEATH

1 year

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/3/1948, to 7-8, 1950, that I last saw the  
deceased alive on 1/12, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

R. Harris

23B. ADDRESS

M. D.

1927 E. North Ave.

23C. DATE SIGNED

7/10/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/12/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JUL 11 1950

VS 150

5234A

477

WATLEY

OFFICE OF THE ATTORNEY GENERAL

STATE OF MISSISSIPPI

IN SENATE

COMMITTEE ON

EDUCATION

REPORT

OF THE

COMMISSIONER

OF EDUCATION

FOR THE

YEAR 1900

Presented to the Senate

at the Session of 1901

January 15, 1901

By J. M. WATLEY,

Attorney General.

1901

MISSISSIPPI

1901

MISSISSIPPI



260

50 6064

BUSER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6064

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>George A. Buser</b>		2. DATE OF DEATH <b>7/9/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>822<sup>N</sup> Woodington Rd</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto 16-08</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>822<sup>N</sup> Woodington Rd.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 11<sup>th</sup> 1858</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Md. Club</b>	9. AGE (In years last birthday) <b>92</b> If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
13. FATHER'S NAME <b>Michael Buser</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Geo. E. Buser 1712 Bolton St.</b>		ADDRESS _____	
18. <b>450.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerosis, general, severe</b>		CAUSE OF DEATH (A) DUE TO _____ (B) DUE TO _____ (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH _____	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>19 Feb. 1949</b> to <b>9 July, 1950</b> , that I last saw the deceased alive on <b>9 July, 1950</b> and that death occurred at <b>6:10 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Mr. Theodore Buser</b>		23B. ADDRESS <b>Md. Arts Bldg</b>	
23C. DATE SIGNED <b>10 July 50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/12/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wm Cook Inc. 1217 St. Paul St.</b>	
25. FUNERAL DIRECTOR		ADDRESS	

MEDICAL CERTIFICATION

1915

July 1-1915

July 2-1915

1915

July 3-1915

July 4-1915

July 5-1915

July 6-1915

July 7-1915

July 8-1915

July 9-1915

July 10-1915

July 11-1915

July 12-1915

July 13-1915

July 14-1915



200

50

6065

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50

6065

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FLORENCE F. RICE

2. DATE  
OF  
DEATH

JULY 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

SINAI HOSPITAL

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

SINGLE

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Seamstress Hunt Mfg. Co

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Nicholas Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

7/7/1886

9. AGE (In years last birthday)

63

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Barbara M. Wehner

17. INFORMANT

ADDRESS

Joseph L. Rice 2033 W. Saratoga St.

18. 181X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO-VASCULAR LESION

1 1/2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) GENERALIZED ARTERIOSCLEROSIS

4 YRS

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) CARCINOMA OF BLADDER

1 1/2 YRS

19A. DATE OF OPERATION

JUNE 21, 1950

19B. MAJOR FINDINGS OF OPERATION

BREAKDOWN OF ARTIFICIAL BLADDER

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from OCT 20, 1949 to JULY 10, 1950, that I last saw the deceased alive on JULY 10, 1950, and that death occurred at 6:25 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Molander E. Ruben

M. D.

23B. ADDRESS

SINAI HOSPITAL

23C. DATE SIGNED

7/10/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/13/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

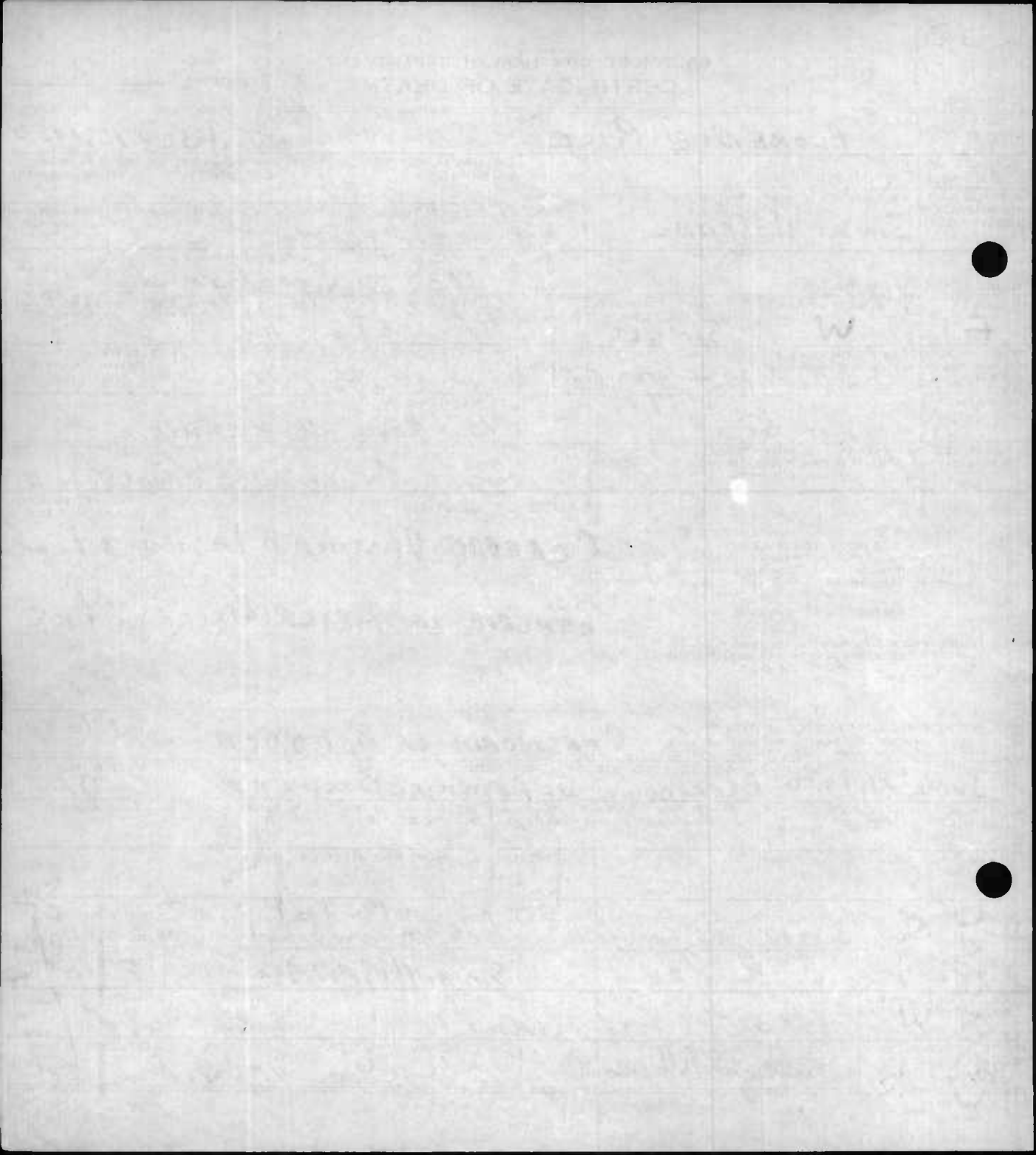
Wm. Cook Inc. 1217 St. Paul St.

VS 150

6904 G 6066

52B

MEDICAL CERTIFICATION



460

50 6066

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6066

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Robert O. Miller

2. DATE  
OF  
DEATH

7/10/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

West Balto. Genl.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Robert O. Miller

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. 16-06

D. STREET ADDRESS (If rural, give location)

2874 W. Lanvale St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Oct 1884

9. AGE (In years  
last birthday)

65

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Undergarment Foundry

10B. KIND OF BUSINESS OR  
INDUSTRY

Brother - Machine Oil Burner Co.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Miller

14. MOTHER'S MAIDEN NAME

Melvina

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

217-01-2954

17. INFORMANT

ADDRESS

Doris Henderson 2108 Bolton St.

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cerebrovascular Accident

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular Disease

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from 7-8, 1950, to 7-10, 1950, that I last saw the  
deceased alive on 7/10, 1950, and that death occurred at 1A m., from the causes and on the date stated above.

23A. SIGNATURE

Jerome Gaher

M. D.

23B. ADDRESS

Lutheran Hosp.

23C. DATE SIGNED

7/10/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 11 1950

Huntington Williams, M.D.

Wm. Bok Inc. 1217 St. Paul St.

VS 150

69030067

937

MEDICAL CERTIFICATION

DEATH CERTIFICATE

1901

1901

1901

1901

1901

1901

1901

1901

1901

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6067

BIRTH NO. 50 6067

1. NAME OF DECEASED (Type or Print) <b>James L. Webb, Jr.</b>			2. DATE OF DEATH <b>July 10, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 18-01</b>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>824 W. Baltimore St.</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. <del>SINGLE, MARRIED, WIDOWED, DIVORCED</del> (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6/29/1890</b>		9. AGE (In years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Highway Dept</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va</b>
13. FATHER'S NAME <b>James L. Webb</b>			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Lydia M. Webb</b>			ADDRESS <b>824 W. Balto. St.</b>		

18. <b>4/22/1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) ..... DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) ..... DUE TO		
(C) .....		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inq.</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					

23A. SIGNATURE <b>R S Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 10, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/12/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wm Cook Inc.</b>		25. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul St.</b>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6068

50 6068

BIRTH NO. 400

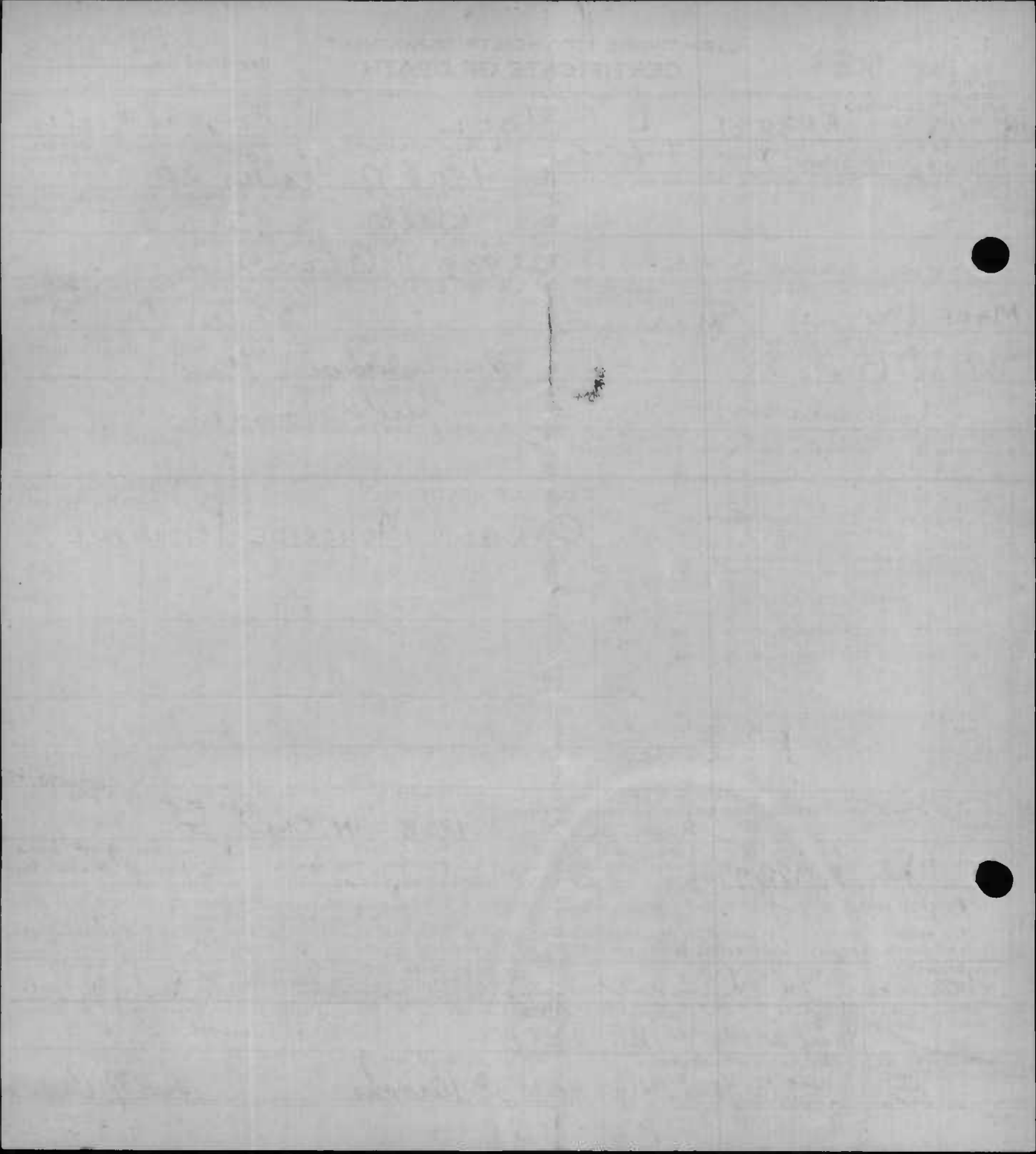
50 6068

1. NAME OF DECEASED (Type or Print) <b>ROBERT L. TOOL</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Mary Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>THIS IS A WHITE CASE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto 12-05</b>	
6. Length of stay in Baltimore <b>5 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>1908 N. Charles St</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>27 yrs</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <b>Metal Bailer</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>Minneapolis Minn</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT		ADDRESS	

18. <b>E977.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <b>CARBON MONOXIDE POISONING</b> (A) DUE TO  (B) DUE TO  (C)	INTERVAL BETWEEN ONSET AND DEATH
---	---	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>apt #5 1908 N. Charles St</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 8, 1950 7<sup>05</sup> PM</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Deceased put head in oven, one burner on; found dead by neighbor</b>	
22. I certify that I took charge of the remains described above, held an <b>Inspection + Inquiry</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Stanley H. Durlacher M.D.</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>July 9, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>July 12-1950</b>		24B. DATE <b>July 12-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. LOCATION (City, town, or county) <b>Baltimore</b>		24F. LOCATION (City, town, or county) <b>Baltimore</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>		25. FUNERAL DIRECTOR <b>14 Brooks</b>	
VS 151		N-968.0		6903F	
				163H	

MEDICAL CERTIFICATION



163

50 6069

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6069

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank E. Lubertine

2. DATE  
OF  
DEATH

7/9/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

City Hosp.

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Mill Hand

10B. KIND OF BUSINESS OR  
INDUSTRYRevere Brass &  
Copper co.

13. FATHER'S NAME

Anton Lubertine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

1

16. SOCIAL  
SECURITY NO.

216-03-3863

17. INFORMANT

3411 SS

Mrs. Mary E. Lubertine Elloitt St.

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Acute Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Arteriosclerosis of Coronary  
artery.

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)22. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK22. I hereby certify that I attended the deceased from July 7, 1950, to July 9, 1950, that I last saw the  
deceased alive on July 7, 1950, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

304257 Canal St Baltimore

7/10/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-12-50

Sacred Heart

Baltimore

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 11 1950

T. M. Williams, M.D.

John A. Moran

3000 E. Baltimore St.

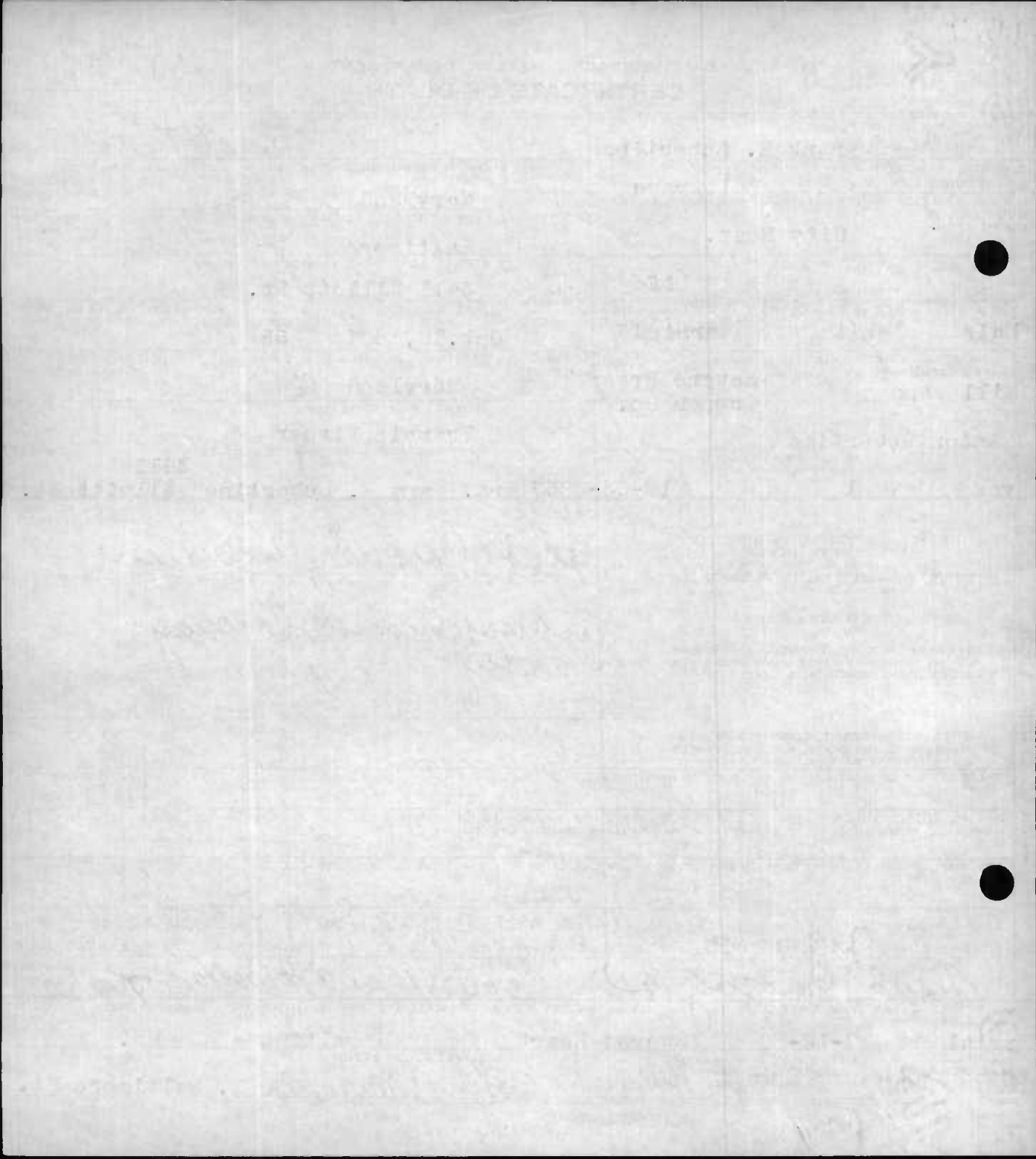
VS 150

(Deraghty)

6903C

94a

MEDICAL CERTIFICATION



600  
50 6070

BALTIMORE CITY HEALTH DEPARTMENT

Families Coming from Calif  
CERTIFICATE OF DEATH

Registered No.

50 6070

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Horbert L. Gray</b>		2. DATE OF DEATH <b>7-9-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>40 So. Decker Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>40 So. Decker Ave.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>7-3-1877</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing (R) JEWELRY</b>	9. AGE (In years last birthday) <b>73</b>
13. FATHER'S NAME <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>?</b>	
17. INFORMANT <b>Mrs. Lillian Kneller. Homestead St.</b>		18. ADDRESS <b>1318</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>coronary thrombosis</b>	CAUSE OF DEATH (A) <b>coronary thrombosis</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) DUE TO	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 7, 1950</b> , to <b>July 8, 1950</b> , that I last saw the deceased alive on <b>July 8, 1950</b> , and that death occurred at <b>8 P</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Benton V. Lock MD</b>		23B. ADDRESS <b>2936 E. Baltimore St</b>		23C. DATE SIGNED <b>7/9/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/17/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>John A. Moran</b>	
VS 150		49065		3000 E. Baltimore S	

94a

STATE OF CALIFORNIA

County of \_\_\_\_\_

City of \_\_\_\_\_

State of California



340

MARIE METALLO  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6071

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marie Metallo METALLO

2. DATE OF DEATH July 10 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Dundalk

C. Length of stay in Baltimore

45 yrs

5. SEX

F

6. COLOR OR RACE

N White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

4-24-71

9. AGE (In years last birthday)

19

10. Under 1 Year Months Days

18

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

home

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Nicola Fiorentino

14. MOTHER'S MAIDEN NAME

Filomena Rossi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Patrick Metallo (son) as above

18. 422.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tubercular pneumonia

3-4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Congestive failure  
(C) Arteriosclerotic cardiac-vascular disease

?

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7-8, 1950 to 7-10, 1950 that I last saw the deceased alive on 7-10, 1950, and that death occurred at 7:25 a.m., from the causes and on the date stated above.

23. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 13 1950

St. Stanislaus Cemetery

Dundalk Ave Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTERED SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 11 1950

Frank J. Williams, M.D.

Frank Della Hove

322 S. High St.

VS 150

108

July 10 1950

45 yrs

18

W.B.

William Henry

William Henry

no

July 10 1950

SEE 3. High 20.

300  
50 6072

B.C. 50-13572

BALTIMORE CITY HEALTH DEPARTMENT

50 6072

Registered No.

BIRTH NO.

CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) <i>Phyllis Ann</i> <i>Leahy Isid Jett</i>		2. DATE OF DEATH <i>July 11, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>HLH Penn</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>23-03</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1628 Belarhson St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>7-3-50</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>		11. BIRTHPLACE (State or foreign country) <i>Bacto. Md.</i>	
10B. KIND OF BUSINESS OR INDUSTRY —		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Phillip C. Jett</i>		14. MOTHER'S MAIDEN NAME <i>Ruth V. Jett</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Phillip C. Jett</i>		ADDRESS <i>JOHNS HOPKINS HOSPITAL 1628 Clarkson St.</i>	

18. <i>760.5</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Intracranial hemorrhage</i>	CAUSE OF DEATH (A) <i>Intracranial hemorrhage</i> DUE TO (B) <i>Prematurity</i> DUE TO (C) —	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>7-3-</i> , 19 <i>50</i> to <i>7-11-</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-11-</i> , 19 <i>50</i> and that death occurred at <i>6:45 a.m.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>Lenny M. Seidel</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>July 11, 1950</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 11, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>	24D. LOCATION (City, town, or county) (State) <i>A. A. Co. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 11 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, MD</i>		25. FUNERAL DIRECTOR <i>A. Howard Evans</i>
				ADDRESS <i>1400 S. Charles St</i>

6073

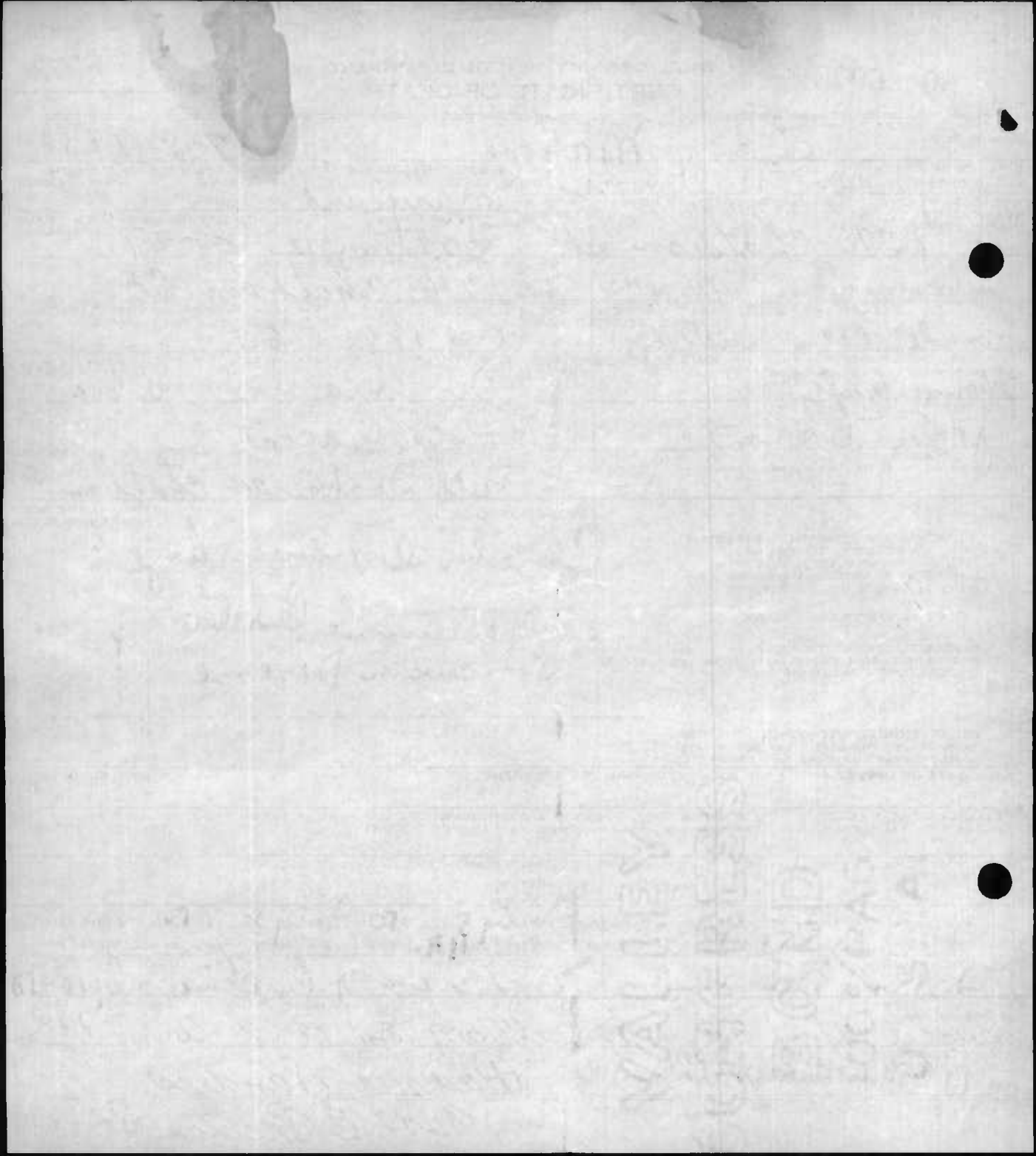
160a

MEDICAL CERTIFICATION

International  
Business

Handwritten notes at the bottom of the page, including the date "11/11/34" and the phrase "Handwritten notes".







535

6074

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6074  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Thomas MUNTEAN</b>		2. DATE OF DEATH <b>7-10-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-07</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Bon Secours Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>401 S. Lehigh -</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>5-16-92</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel Co.</b>	
13. FATHER'S NAME <b>Caron Muntean</b>		12. CITIZEN OF WHAT COUNTRY? <b>Rumania</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Eliz. Muntean</b>		ADDRESS <b>(401 S. Lehigh St)</b>	

18. <b>156.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of liver</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C)</b>		
19A. DATE OF OPERATION <b>6-30-50</b>	19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Liver</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6/23/50**, 19**50**, to **7-10-50**, 19**50**, that I last saw the deceased alive on **7-10-50**, 19**50**, and that death occurred at **m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>M. M. M. M.</b>	23B. ADDRESS <b>Bon Secours Hospital</b>	23C. DATE SIGNED <b>10-7-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-14-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>Balto., Co., Md</b>	25. FUNERAL DIRECTOR <b>John S. Connolly - 418 Eastern Ave</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>William M. M.</b>

VS 150  
M. M. M. M. 6903A  
Balto 21 46F md

MEDICAL CERTIFICATION

26. 7140

263

6075 JL- 100672

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6075

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Weigert

2. DATE  
OF  
DEATH

7-9-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Md.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street address or

Baltimore City Hospitals

4940 Eastern Ave.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

221 Old North Point Rd.

5300

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Feb. 13 1891

9. AGE (in years  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Henry Moll

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18. 332X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Quadriplegia

DUE TO

(C) Cerebral Thrombosis

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-17-46, 19, to July 9, 1950 that I last saw the  
deceased alive on July 9, 1950 and that death occurred at 12.15AM from the causes and on the date stated above.

23A. SIGNATURE

R. S. Boyer M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

7-9-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-12-50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cem

24D. LOCATION (City, town, or county) (State)

Balto., Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

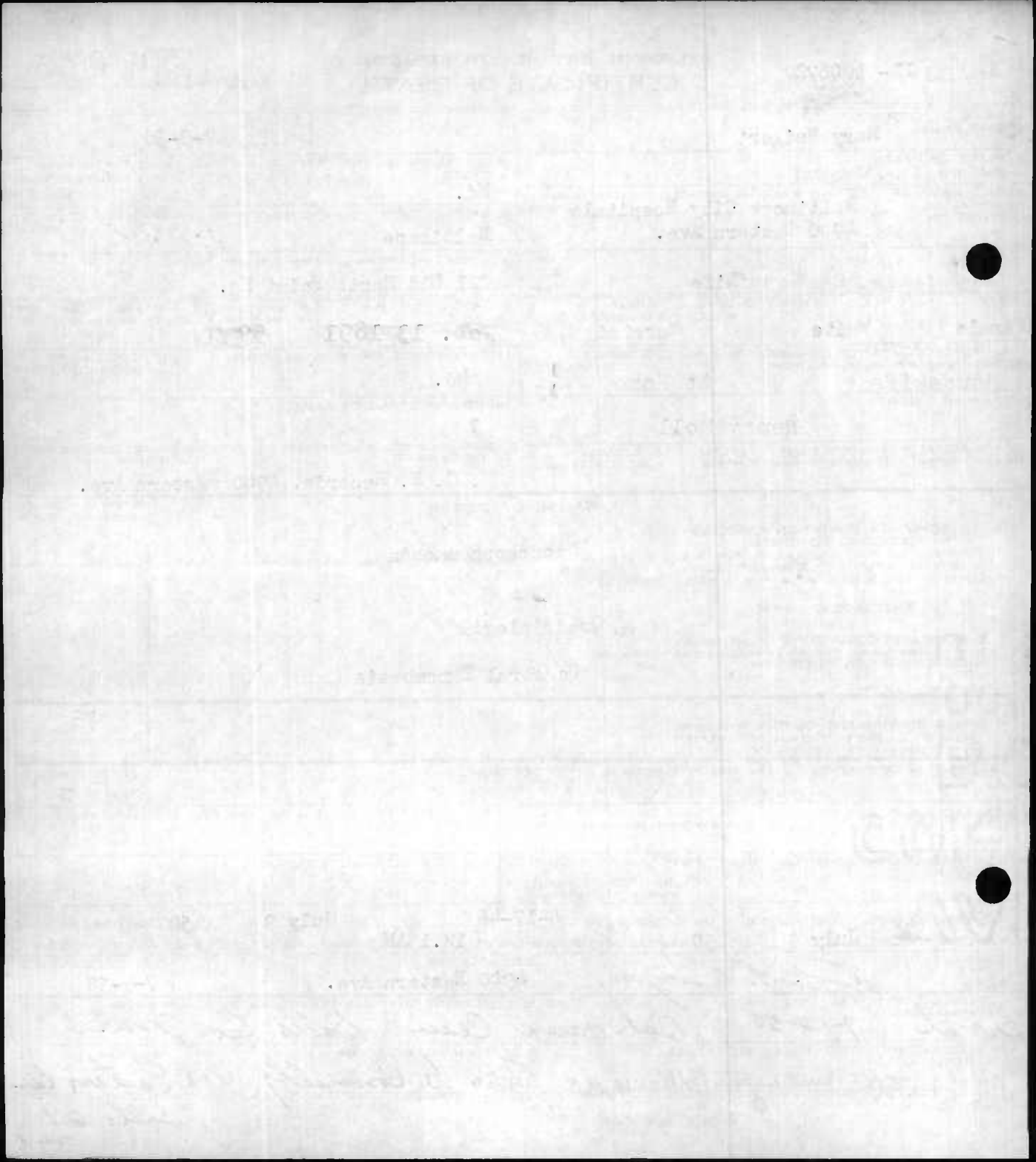
ADDRESS

John S. Connolly 418 Eastern Ave

JUL 11 1950

VS 150

836 Balto 21  
Md.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

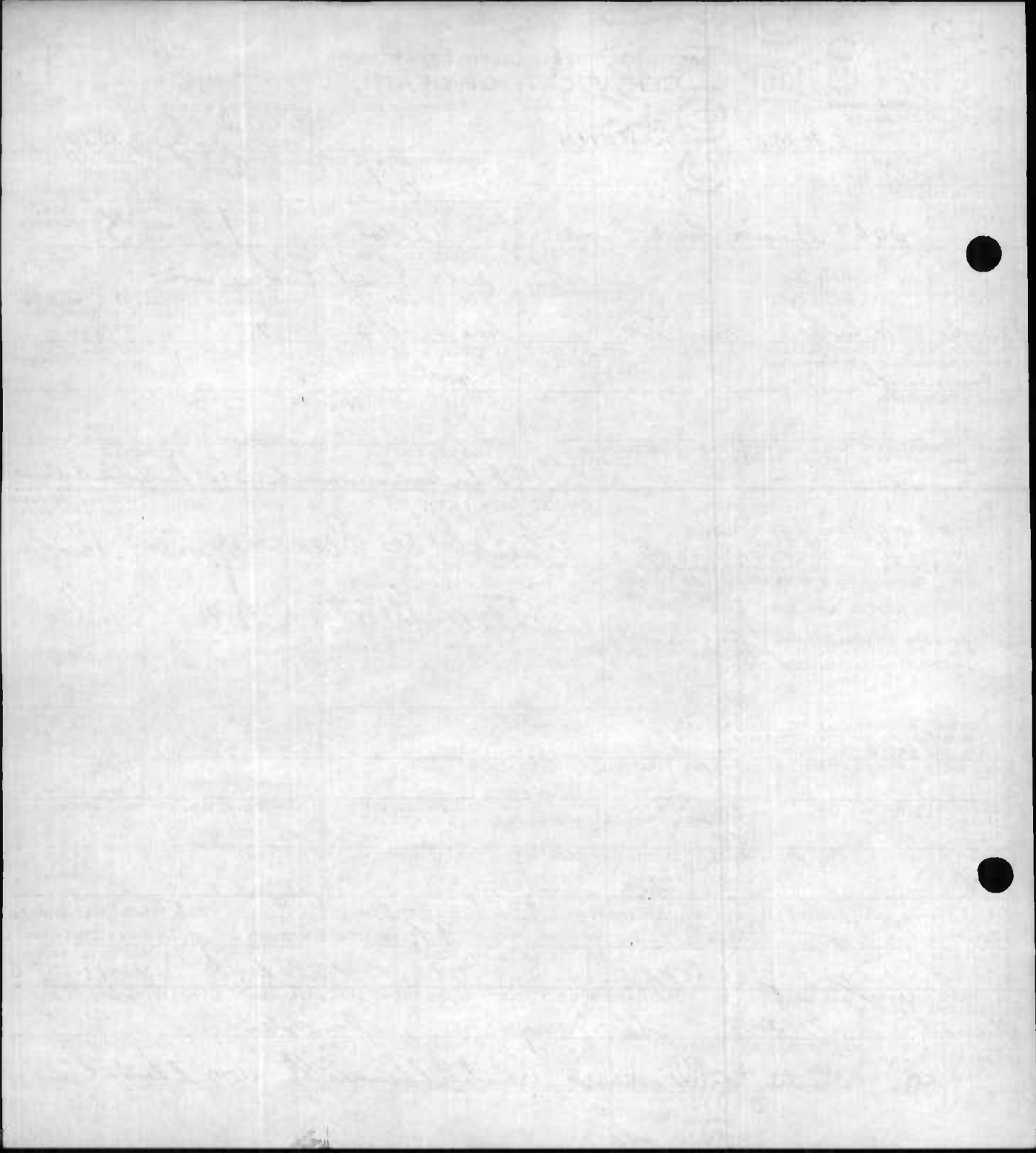
50 6076  
Registered No. \_\_\_\_\_

650  
0 6076  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>EMMA J BROWN</b>		2. DATE OF DEATH <b>July 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived or institution: residence before admission) A. STATE <b>md.</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2069 Druid Park Drive</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto 13-08</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>2069 Druid Park Drive</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 31, 1892</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years; last birthday) <b>57</b>
13. FATHER'S NAME <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		12. CITIZEN OF WHAT COUNTRY? —	
16. SOCIAL SECURITY NO. —		14. MOTHER'S MAIDEN NAME <b>?</b>	
17. INFORMANT <b>Charles C Brown Sr. 2069 Druid Park Drive</b>		ADDRESS —	

18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Decomposition</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>  <b>?</b>
(A) DUE TO <b>Anteroseptal CVD</b>		
(B) DUE TO —		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7-9</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5-1</b> , 19 <b>50</b> to <b>7-9</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-9</b> , 19 <b>50</b> and that death occurred at <b>4 A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Laurence H. Harnish</b>		23B. ADDRESS <b>3711 Fall Rd</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/12/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St Marys</b>	
24D. LOCATION (City, town, or county) (State) <b>Hampden</b>		25. FUNERAL DIRECTOR <b>Paul E. Harnish</b>		ADDRESS <b>3615-11 Chestnut Ave.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>11-11-1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Paul E. Harnish</b>	





525  
0 6077  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6077

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Curtis Benjamin		7/10/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE	
1230 Glenhaven Rd		Md	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		B. COUNTY	
13-05		Baltimore Md	
D. STREET ADDRESS (If rural, give location)		2900 Keswick Rd	
c. Length of stay in Baltimore		Yrs. Mos. Days	
5. SEX		6. COLOR OR RACE	
M		W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
Married		April 23 1886	
9. AGE (In years last birthday)		64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Maintenance		Md.	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
Baltimore City			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
?		?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
-		-	
17. INFORMANT		ADDRESS	
Emma J. Benjamin		2940 Keswick Rd.	

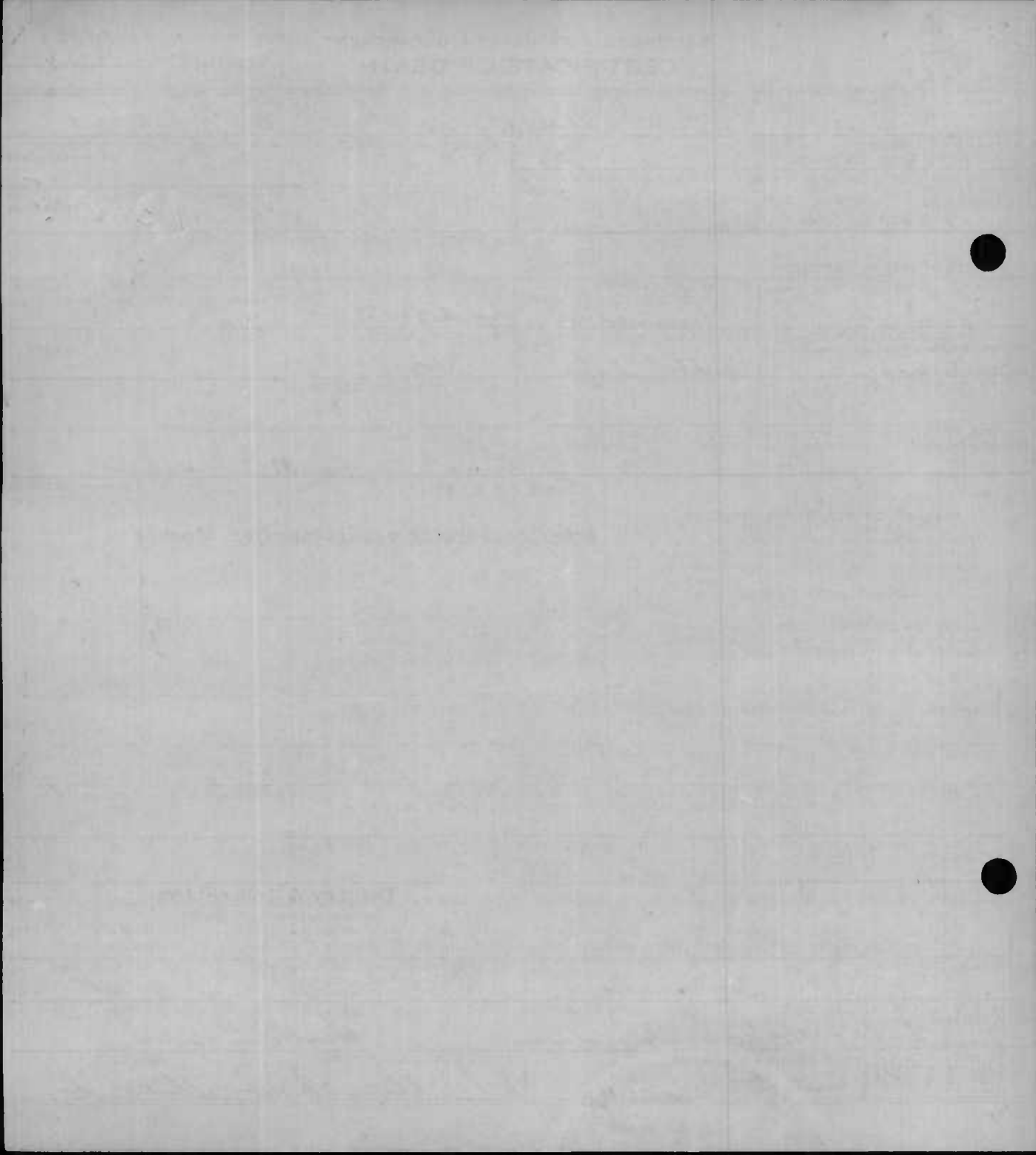
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) Arteriosclerotic cardiovascular disease		DUE TO			
ANTECEDENT CAUSES		(B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19a. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
0				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE		23b. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> M.D.		23c. DATE SIGNED	
[Signature]				2/10/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
Burial		7/10/50		Woodlawn	
24d. LOCATION (City, town, or county)		24e. FUNERAL DIRECTOR		ADDRESS	
Woodlawn Md.		Paul E. Chenoweth		3610 W. Chestnut Ave.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
JUL 11 1950		[Signature]		ADDRESS	

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432  
50 6078BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6078  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Margaret M. Shultz</i>		2. DATE OF DEATH <i>July 9, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2918 Markley Ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-02</i>			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2918 Markley Ave</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Mar. 9-1868</i>	9. AGE (In years last birth day) <i>82</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during the last working life, even if retired) <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Miss Ida Schwartz - 2923 Markley</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1</i> DUE TO (A) <i>Acute coronary infarction</i> ANTECEDENT CAUSES DUE TO (B) <i>Coronary sclerosis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>11</i> 19 <i>49</i> to <i>July 6th</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7/6</i> , 19 <i>50</i> , and that death occurred at <i>1304</i> <i>am</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>A. H. Hornstein</i>		M. D. <i>204 E. Broad St</i>		23C. DATE SIGNED <i>7/10/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/13/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	
24D. LOCATION (City, town, or county) (State) <i>Balt. Md</i>		24E. FUNERAL DIRECTOR <i>L. J. Luck, 5305 Bayford</i>		24F. ADDRESS	

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Dr. Hornstein  
204 E. Biddle St.

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6079

Registered No.

1. NAME OF DECEASED (Type or Print) <b>William H. Thomas</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balto.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>615 W. Barre St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto.</b>	
D. STREET ADDRESS (If rural, give location) <b>615 W Barre St.</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. Mos. Days	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 3, 1889</b>
9. AGE (In years, last birthday) <b>67</b>		10. UNDER 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Emily Young</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Bertha Thomas</b>		ADDRESS <b>615 W Barre St.</b>	

MEDICAL CERTIFICATION

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure</b> DUE TO <b>Hemiplegia</b> DUE TO <b>Hypertensive arteriosclerosis</b> <b>Cardio-vascular renal disease</b>		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 17</b> to <b>July 8</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 7</b> , 19 <b>50</b> and that death occurred at <b>5:08 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>D. Shorsfley M.D.</b>		23B. ADDRESS <b>601 N. Monroe St.</b>	
23C. DATE SIGNED <b>7/11/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-12-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		25. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>	
REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		ADDRESS <b>Schroeder St.</b>	

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RECEIVED

WILLIAM H. THOMAS

MD

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1875

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536  
BIRTH NO. 6080

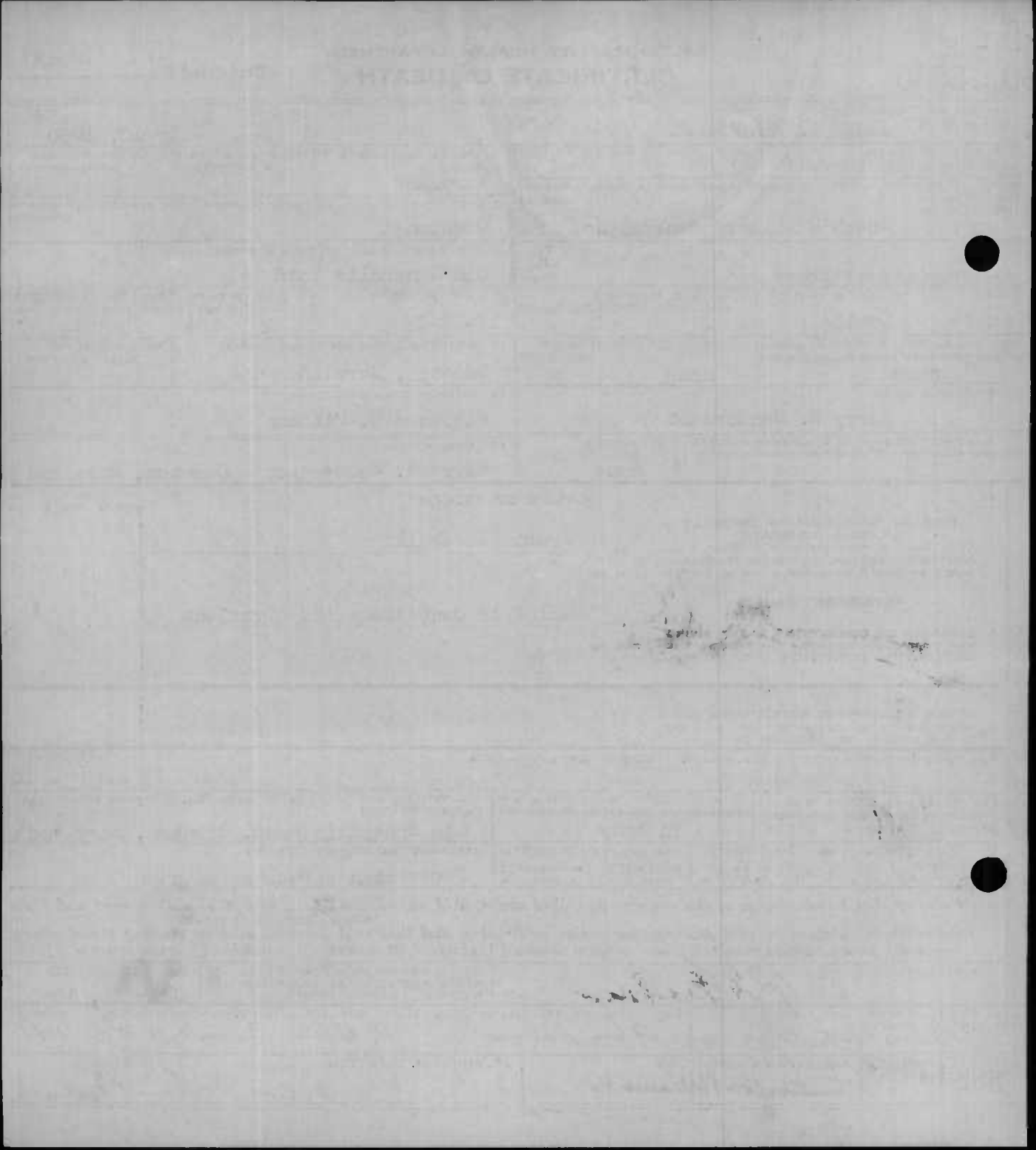
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6080

1. NAME OF DECEASED (Type or Print) <b>JAMES W. HENDERSHOT</b>			2. DATE OF DEATH <b>July 10, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Odenton</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>Old Annapolis Road</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>12-28-47</b>	9. AGE (In years last birthday) <b>2</b>	10. Under 1 Year Months: Days: 11. Under 24 Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>		
13. FATHER'S NAME <b>Harry W. Hendershot</b>			14. MOTHER'S MAIDEN NAME <b>Florence E. Pittman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>none</b>		
17. INFORMANT <b>Harry W. Hendershot</b>			ADDRESS <b>Odenton, Maryland</b>		

18. <b>E812.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fractured skull</b> DUE TO (A) <b>Fractured skull</b> (B) <b>Multiple contusions and abrasions</b> DUE TO (C) <b>Multiple contusions and abrasions</b>	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>July 10, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>highway</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>highway</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Old Annapolis Road, Odenton, Maryland</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 10, 1950 3.40p.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>	
22. I certify that I took charge of the remains described above, held an <b>Inquiry &amp; Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 11, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 13, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, D. A. Co. 148.</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		24F. LOCATION (City, town, or county) (State) <b>Glen Burnie, D. A. Co. 148.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. H. Williams, M.D.</b>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6081  
Registered No. \_\_\_\_\_

660  
6081  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EMMA M. HARRIER</b>		2. DATE OF DEATH <b>7-10-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Doctors Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>DOCTORS Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 12-05</b>	
c. Length of stay in Baltimore <b>30 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>1814 N. Calvert St.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Unknown</b>
9. AGE (In years last birthday) <b>about 74</b>		10. UNDER 1 Year: Months _____ Days _____ 11. UNDER 24 Hours: Hours _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mr. Frank Albright-Schenectady 8, N.Y.</b>		ADDRESS _____	

<p>18. <b>472.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>CAUSE OF DEATH</p> <p>(A) <b>Chronic Myocarditis</b></p> <p>DUE TO</p> <p>(B) <b>Arteriosclerotic Cardiovascular Disease</b></p> <p>DUE TO</p> <p>(C) <b>Bronchopneumonia</b></p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>5 months</b></p> <p><b>3 days</b></p>
--	--	---

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from <b>Feb. 3, 1950</b>, to <b>July 10, 1950</b>, that I last saw the deceased alive on <b>July 9, 1950</b>, and that death occurred at <b>2001</b> m., from the causes and on the date stated above.</p>					
23A. SIGNATURE <b>Samuel B. Wolfe</b>		23B. ADDRESS <b>1331 E. North Ave</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/12/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Dickner</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>Wm. J. Dickner &amp; Sons - Balto</b>	

Dr. Sam. B. Wolfe  
# 1331 E North Ave

300  
0 6082BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6082

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Ware Foote

2. DATE  
OF  
DEATH

7/8/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Provident Hosp.

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

Negro

7. SINGLE (MARRIED)  
WIDOWED, DIVORCED (Specify)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 17-01  
726 Wilmer Court

8. DATE OF BIRTH

1895  
II-25-18859. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

54

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

Private

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or oookowo) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Wm.R. Foote 726 Wilmer Court

18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hypertensive Cardiovascular Dis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Auricular Fibrillation

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/16 1950 to 7/8 1950 that I last saw the  
deceased alive on 7/7 1950 and that death occurred at 2:59 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

John H. Holmes III M. D.

Provident Hosp.

7/8/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7 July 50

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn

24D. LOCATION (City, town, or county)

(State)

Baltimore 30, Md.,

DATE RECEIVED BY  
LOCAL REGISTRAR

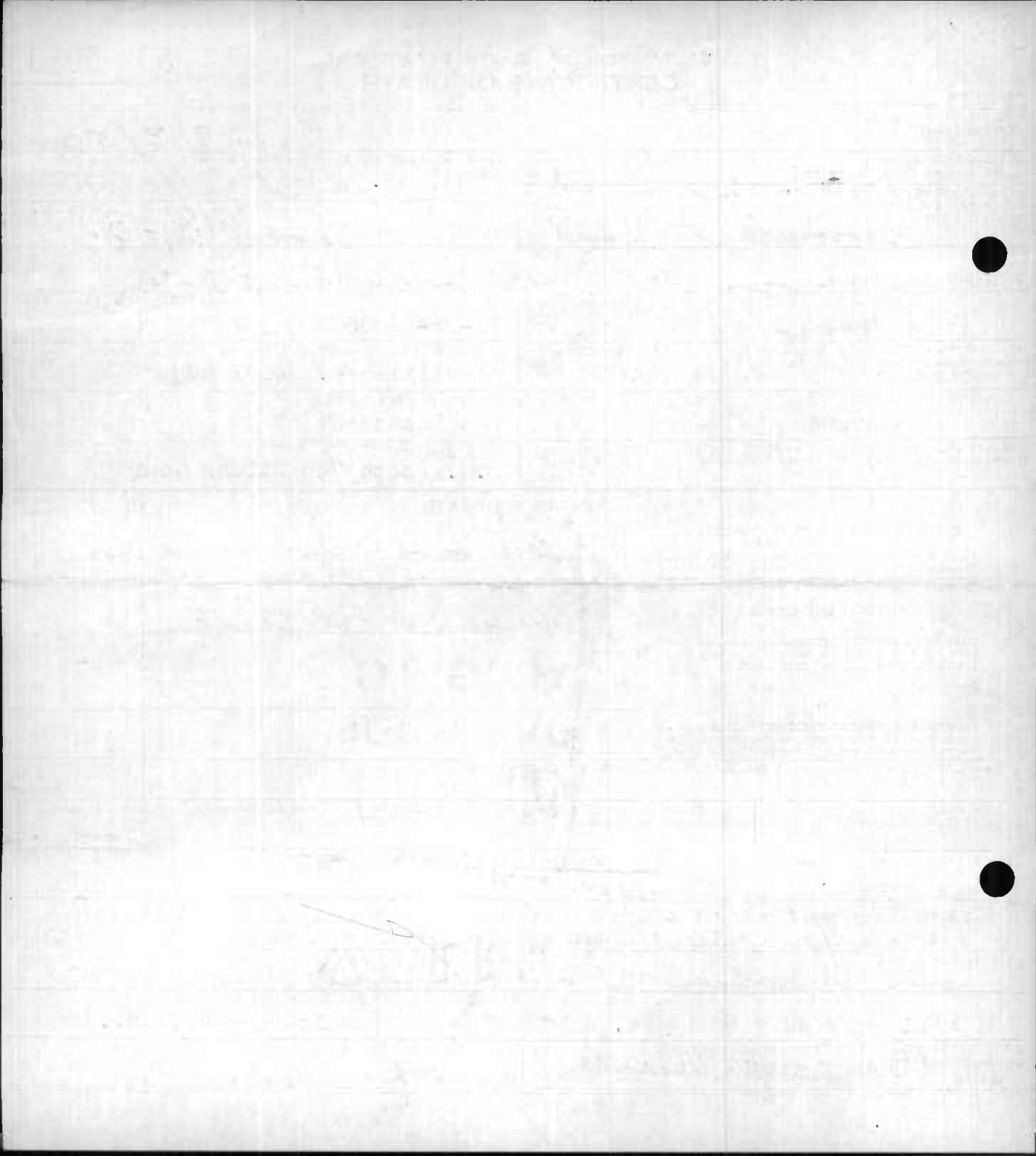
REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

Wm.A. Jackson - 916 PENNA. AVE.





654

6083

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6083

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Emma N. Arnold

2. DATE  
OF  
DEATH

7-9-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Maryland General Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

16-07

D. STREET ADDRESS (If rural, give location)

2242 Winchester St #16

C. Length of stay in Baltimore

45

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

M

8. DATE OF BIRTH

3-16-1885

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

West, Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Allen

Newman

14. MOTHER'S MAIDEN NAME

ELLEN SULLIVAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Clyde Arnold as above

18. 292.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Hepato-renal failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Acquired hemolytic anemia

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATHunknown  
duration  
many yrsII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Cholelithiasis? (Cholelithiasis)  
(12/12/49)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-4, 1950, to 7-9, 1950, that I last saw the  
deceased alive on 7/9, 1950, and that death occurred at 3:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Marguerite Louise Andler

M. D.

23B. ADDRESS

Md. General Hosp.

23C. DATE SIGNED

7-9-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

July 12/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION (City, town, or county)

Balt. Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Harry H. Witke 4101 Edmondson Ave.

JUL 11 1950

VS 150

73D

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Patented June 1, 1909

Application filed

March 1, 1908

of the

Patent Office

Washington, D. C.

Serial No. 444,444

Class

Plant Industry

Patent No. 844,444

U.S. Pat. No. 844,444

Patented June 1, 1909

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6084  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Ethel L. LIESMANN</b>		2. DATE OF DEATH <b>July 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>16-08</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>3814 Harlem Avenue</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>April 15, 1934</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>16</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Rev. Justus H. Liesmann</b>		14. MOTHER'S MAIDEN NAME <b>Mardelly Tipton Liesmann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <b>Rev. Justus H. Liesmann, 3814 Harlem Av</b>	

18. <b>E843X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Traumatic rupture of liver with massive peritoneal hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Bridge</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Foot bridge near Jolly Acres Camp</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 9, 1950 4:00 P. m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell 15 ft. from bridge to rocky embankment while riding bicycle</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R S Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 10, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 13 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Ferguson</b>		24D. LOCATION (City, town, or county) (State) <b>Gettysburg Penna</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Jr.</b>		25. FUNERAL DIRECTOR <b>Harry H. Witzke</b>		ADDRESS <b>4101 Edmondson</b>	

MEDICAL CERTIFICATION

WATGROSS CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of witness		12. Signature of witness	
13. Signature of witness		14. Signature of witness		15. Signature of witness		16. Signature of witness	
17. Signature of witness		18. Signature of witness		19. Signature of witness		20. Signature of witness	
21. Signature of witness		22. Signature of witness		23. Signature of witness		24. Signature of witness	
25. Signature of witness		26. Signature of witness		27. Signature of witness		28. Signature of witness	
29. Signature of witness		30. Signature of witness		31. Signature of witness		32. Signature of witness	
33. Signature of witness		34. Signature of witness		35. Signature of witness		36. Signature of witness	
37. Signature of witness		38. Signature of witness		39. Signature of witness		40. Signature of witness	
41. Signature of witness		42. Signature of witness		43. Signature of witness		44. Signature of witness	
45. Signature of witness		46. Signature of witness		47. Signature of witness		48. Signature of witness	
49. Signature of witness		50. Signature of witness		51. Signature of witness		52. Signature of witness	
53. Signature of witness		54. Signature of witness		55. Signature of witness		56. Signature of witness	
57. Signature of witness		58. Signature of witness		59. Signature of witness		60. Signature of witness	
61. Signature of witness		62. Signature of witness		63. Signature of witness		64. Signature of witness	
65. Signature of witness		66. Signature of witness		67. Signature of witness		68. Signature of witness	
69. Signature of witness		70. Signature of witness		71. Signature of witness		72. Signature of witness	
73. Signature of witness		74. Signature of witness		75. Signature of witness		76. Signature of witness	
77. Signature of witness		78. Signature of witness		79. Signature of witness		80. Signature of witness	
81. Signature of witness		82. Signature of witness		83. Signature of witness		84. Signature of witness	
85. Signature of witness		86. Signature of witness		87. Signature of witness		88. Signature of witness	
89. Signature of witness		90. Signature of witness		91. Signature of witness		92. Signature of witness	
93. Signature of witness		94. Signature of witness		95. Signature of witness		96. Signature of witness	
97. Signature of witness		98. Signature of witness		99. Signature of witness		100. Signature of witness	

626  
6085BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6085

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		BARBARA M. FRAZIER		July 9, 1950.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		613 S. Clinton St.			
B. FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			
c. Length of stay in Baltimore		Yrs. Mos. Days			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months Days
Female	White	Widowed	October 16, 1874	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		House Work		Baltimore, Md.	
13. FATHER'S NAME		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
Matthew Frazier		None		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		None		Rose Durkin	
				ADDRESS	
				613 S. Clinton St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
153X		Carcinoma - colon		1 yr.	
DUE TO		(A)			
ANTECEDENT CAUSES		Arteriosclerosis - generalized		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
0				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 7/28 to 7/7, 1950, that I last saw the deceased alive on 7/7, 1950, and that death occurred at 7:30 P.M. from the causes and on the date stated above.		23A. SIGNATURE		23B. ADDRESS	
		L. J. Kline		262 E. Waverly St	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 13 - 1950		Holy Redeemer Cemetery	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
JUL 11 1950		Wm. H. Williams, M.D.		Charles S. Gile	
				ADDRESS	
				901 S. Conkling St.	

3  
11/11/11  
11/11/11



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6086**

**152**  
BIRTH NO. **6086**

1. NAME OF DECEASED (Type or Print) <b>Edward T. Evans</b>			2. DATE OF DEATH <b>7-10-50</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
b. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1737 E 25<sup>th</sup> Street</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 8-05</b>		
c. Length of stay in Baltimore <b>57</b> Yrs. Mos. Days			d. STREET ADDRESS (If rural, give location) <b>1737 E. 25<sup>th</sup> Street</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6/17/1893</b>		9. AGE (In years last birthday) <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mortician</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MORTICIAN</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Charles H Evans</b>		
14. MOTHER'S MAIDEN NAME <b>Catherine Spence</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WWI</b>		
16. SOCIAL SECURITY NO. <b>215-01-7720</b>			17. INFORMANT <b>George H Evans</b> ADDRESS <b>118 W. Mt. Royal Ave</b>		
18. <b>420.1 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Coronary Occlusion -</b> DUE TO <b>(B)</b> DUE TO <b>(C)</b> INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>					
<p align="center"><b>II</b></p> <p align="center"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p align="center"><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>					
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-9</b> 19 <b>50</b> , to <b>7-10</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-10-50</b> , 19 <b>50</b> , and that death occurred at <b>5:30</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>George H Evans</b>		23b. ADDRESS <b>2128 N Calvert Street</b>		23c. DATE SIGNED <b>7-10-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>7/13/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM</b>	
24d. LOCATION (City, town, or county) (State) <b>Baltimore MD</b>		24e. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		24f. REGISTRAR'S SIGNATURE <b>Wilmington Williams, MD</b>	
24g. FUNERAL DIRECTOR <b>Charles H Evans &amp; Son Inc</b>		24h. ADDRESS <b>118 W. Mt. Royal Ave</b>		24i. PHONE NO. <b>94a</b>	

**054815 118 W. Mt. Royal Ave 94a**

10/1/70

Charles F. Brown

212-11-1120

WAT

112

Continued from

11/1/70 11/1/70 11/1/70

11/1/70 11/1/70 11/1/70  
Continued from  
11/1/70 11/1/70 11/1/70

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6087  
Registered No. \_\_\_\_\_

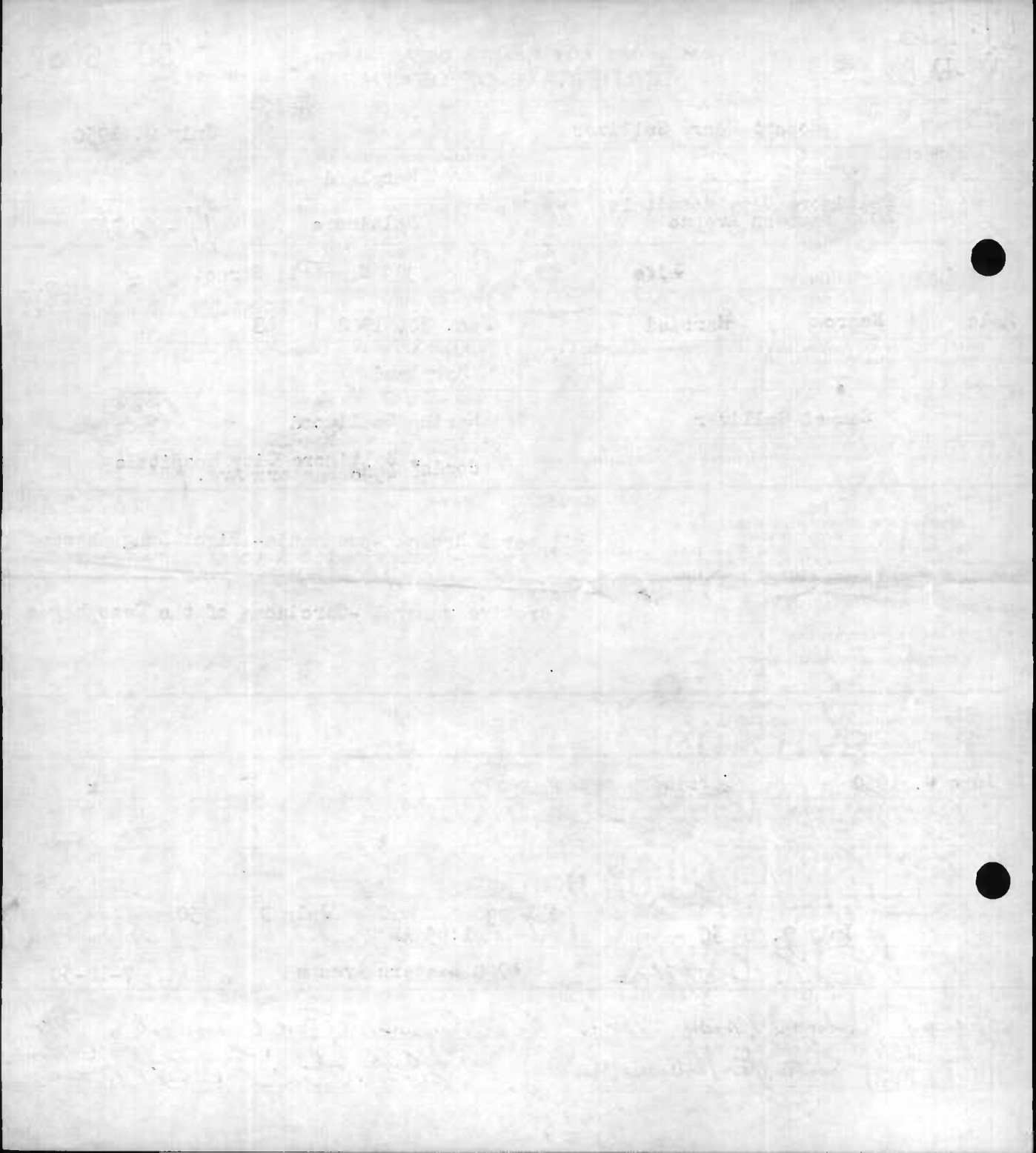
4-16  
5038311087  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Robert Henry Gulliver</b>			2. DATE OF DEATH <b>July 9, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>305 Campbell Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 30, 1902</b>		9. AGE (In years last birthday) <b>48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MOVING VAN CO</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <b>Samuel Gulliver</b>			14. MOTHER'S MAIDEN NAME <b>Martha Smallwood</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Baltimore City Hospitals</b> <b>Records* 4940 Eastern Ave.</b>		

18. <b>150X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Bilateral Broncho-pneumonia- Right Lung abscess</b> <b>Left Supra-diaphragmatic Abscess</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Operative removal -Carcinoma of the Oesophagus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>June 7, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma oesophagus</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>May 23</b> , 1950, to <b>July 9</b> , 1950, that I last saw the deceased alive on <b>July 9</b> , 1950, and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.				
23A. SIGNATURE <i>H. Rosen</i>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>7-10-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 12, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Tr. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 11 1950</b>		REGISTRAR'S SIGNATURE <i>W. H. Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Halland</i> <b>1651 Union Hill Ave.</b>



563  
6088BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6088

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Michael T. Leonard

2. DATE  
OF  
DEATH

7/10/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

West Baltimore General Hospital

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2806 Ellicott Drive

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Asst. Chief Peadiem.

10B. KIND OF BUSINESS OR  
INDUSTRY

RAILROAD

13. FATHER'S NAME

PATRICK H. LEONARD

11. BIRTHPLACE (State or foreign country)

BALTIMORE, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

BRIDGET CANLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

NONE

16. SOCIAL  
SECURITY NO.

705-03-8010

17. INFORMANT

Rose Tydings Leonard

ADDRESS

2806 Ellicott Drive

18. 470.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

23A. SIGNATURE

P. J. Lulimb

M.D.

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

7/10/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 11 1950

GEO. L. Schwab 2101 Frederick

AUG.

4-7-32 23 7-2 137432



426

50 6089

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

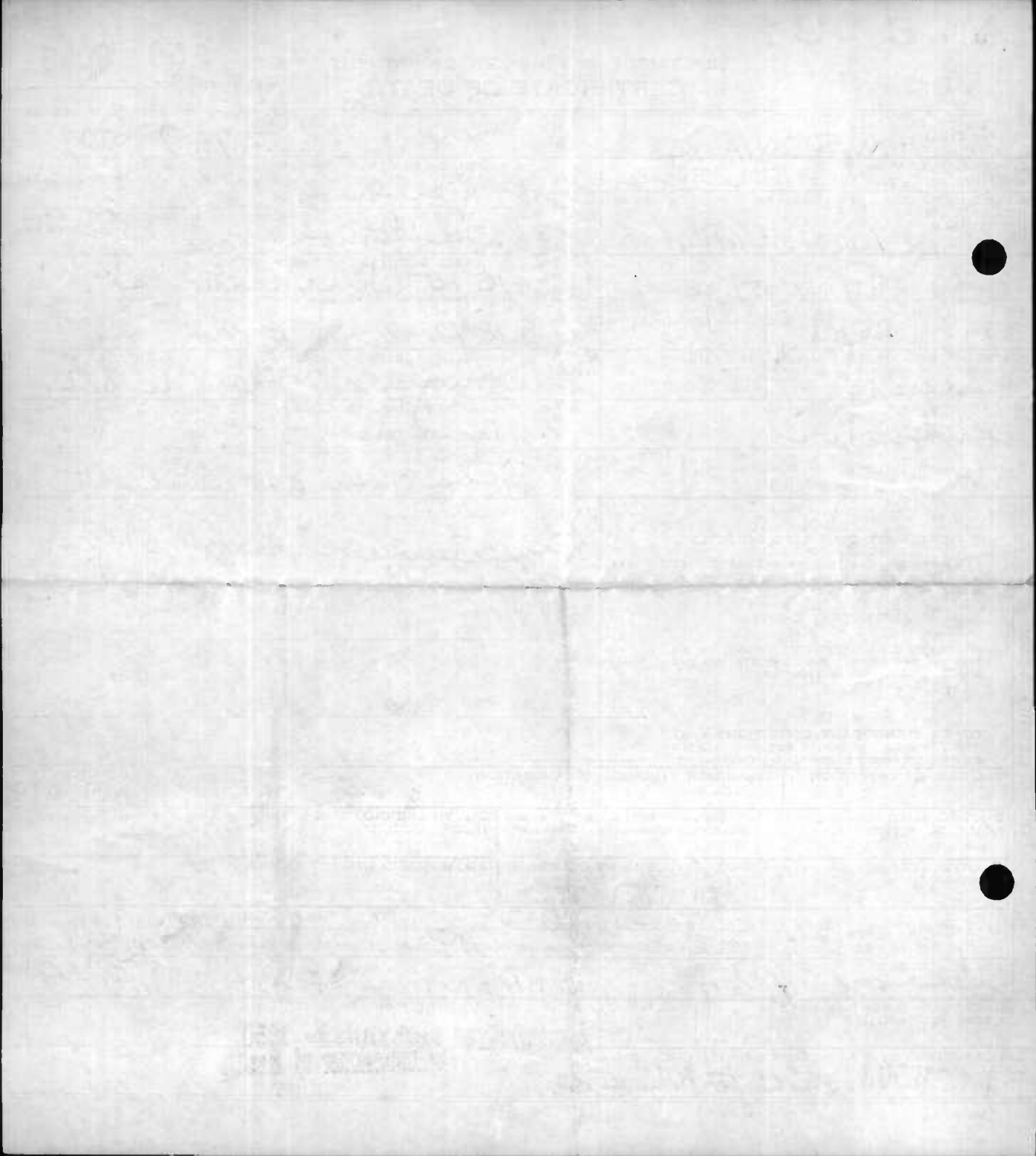
50 6089

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>HOWARD WALKER</b>			2. DATE OF DEATH <b>7-7-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1515 Winchester St</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 16-02</b>		
c. Length of stay in Baltimore <b>50 years</b>			D. STREET ADDRESS (If rural, give location) <b>1515 Winchester St.</b>		
5. SEX <b>m</b>	6. COLOR OR RACE <b>col</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>1872</b>	9. AGE (In years last birthday) <b>78</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>musician</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Howard Co., Md.</b>	
13. FATHER'S NAME <b>unknown</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
14. MOTHER'S MAIDEN NAME <b>unknown</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Julia Owens 1515 Winchester St.</b>		

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive Heart</b>	CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) INJURY	21F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21G. SIGNATURE <b>George Page</b>		21H. M. D. <b>1816 N. Mount St.</b>	
22. I hereby certify that I attended the deceased from <b>6-28-1950</b> to <b>7-7-1950</b> that I last saw the deceased alive on <b>7-6-1950</b> and that death occurred at <b>9:00 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>George Page</b>		23B. ADDRESS <b>1816 N. Mount St.</b>		23C. DATE SIGNED <b>7-7-50.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-11-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>		25. FUNERAL HOME ADDRESS <b>Metropolitan Funeral Home</b>	



536

50 6090

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6090

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>George H. Sanders</b>			2. DATE OF DEATH <b>July 11, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>621 East 35th Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>621 East 35th Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 11, 1873</b>		9. AGE (In years last birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Enamel Burner &amp; Galvanizer</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		

18. <b>241X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial insufficiency 5 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>chronic bronchial asthma 10 yrs.</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **march**, 19**40** to **July 10**, 19**50** that I last saw the deceased alive on **July 10**, 19**50** and that death occurred at **5 A. m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>J. Willis Guyton</b>	23B. ADDRESS M. O. <b>3961 Greenmount Ave.</b>	23C. DATE SIGNED <b>7/11/50.</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>7/13/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. LOCATION (State) <b>Maryland</b>

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>H. M. Cook, Inc.</b>	ADDRESS <b>1217 St. Paul Street</b>
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MEDICAL CERTIFICATION



342  
50 6091  
BIRTH NO. 50-12413MEDLEZ  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6091  
Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Medley Medley		2. DATE OF DEATH 6-18-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Univ. Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt.- 19-02	
c. Length of stay in Baltimore 1 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1614 h Fayette St	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 6-17-50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 Under 1 Year Months: Days 1 Under 24 Hours Hours Min.
13. FATHER'S NAME John V. Medley		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	

18. 762.5 I	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Prematurity, atelectasis	Life
ANTECEDENT CAUSES	(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 6-17, 1950, to 6-18, 1950, that I last saw the deceased alive on 6-18, 1950, and that death occurred at 5:25 P.m., from the causes and on the date stated above.		
23A. SIGNATURE Raymond S. Byrum	23B. ADDRESS M. D. University Hospital	23C. DATE SIGNED 6-27-50

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL	24D. LOCATION (City, town, or county) (State) JUL 5 1950
DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Commissioner of Health	ADDRESS

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1968

DEPARTMENT OF HEALTH

1968

DEPARTMENT OF HEALTH



640  
50 6092BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50 6092

BIRTH NO. 50-14219

1. NAME OF DECEASED  
(Type or Print)

BABY GIRL CARROLL

2. DATE  
OF  
DEATH

6-25-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

University H.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

19-01

D. STREET ADDRESS (If rural, give location)

1623 Pierce St.

c. Length of stay in Baltimore

5 hrs.

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

B

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

6-25-50

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

5

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

A.P. of Univ. Hosp.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Wm. Carroll

14. MOTHER'S MAIDEN NAME

Ellen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ellen Carroll

18. 776 X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Prematurity

5 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-25, 1950, to 6-25, 1950, that I last saw the  
deceased alive on 6-25, 1950, and that death occurred at 5:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Herbert K. Jones M. D.

23B. ADDRESS

23C. DATE SIGNED

6-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL JUL 5 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Commissioner of Health  
Huntington Williams, M.D.

Commissioner of Health

JUL 12 1950

VS 150

159

UNITED STATES DEPARTMENT OF AGRICULTURE

MEMORANDUM

FOR THE RECORD

DATE

TO

FROM

SUBJECT

REFERENCE

REMARKS

CONCLUSION

SIGNATURE

TITLE

DEPARTMENT

DATE

TO

FROM

SUBJECT

REFERENCE

REMARKS

CONCLUSION

SIGNATURE

TITLE

DEPARTMENT

1. NAME OF DECEASED (Type or Print) <b>BABY GIRL STERLING</b>		2. DATE OF DEATH <b>JUNE 27, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 4-02</b>	
C. Length of stay in Baltimore <b>1</b>		D. STREET ADDRESS (If rural, give location) <b>717 W. MULBERRY</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>JUNE 26, 1950</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NEWBORN</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>-</b>
13. FATHER'S NAME <b>UNKNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>GLADYS STERLING</b>	
17. INFORMANT <b>MOTHER</b>		ADDRESS <b>717 W. MULBERRY</b>	

18. <b>762.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>FOETAL ATELECTASIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>PREMATURITY</b>		
19A. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>JUNE 26, 1950</b> , to <b>JUNE 27, 1950</b> that I last saw the deceased alive on <b>JUNE 27, 1950</b> , and that death occurred at <b>4 P</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <i>[Signature]</i>	23B. ADDRESS <b>University Hospital</b>	23C. DATE SIGNED <b>JUNE 30 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>
24D. LOCATION (City, town, or county)		24E. DATE <b>JUL 5 1950</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>		25. FUNERAL DIRECTOR <b>Commissioner of Health</b>
REGISTRAR'S SIGNATURE <i>[Signature]</i>		ADDRESS



350  
50 6094BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6094

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NORA L. EATON

2. DATE  
OF  
DEATH

July 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Franklin Square Hospital

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

24-04

D. STREET ADDRESS (If rural, give location)

1747 Belt Street

C. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Nov. 1919

9. AGE (In years  
last birthday)

30

H Under 1 Year  
Months DaysH Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Johns S. Jenkins

14. MOTHER'S MAIDEN NAME

Catherine Daily

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

William T. Eaton 1747 Belt St.

18. E902.6 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Massive subdural hemorrhage from

MEXED ruptured right tentorium

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Building to street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1419 W. Baltimore Street

19/3

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell to pavement from second floor roof

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. S. Fisher

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

July 10, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

7-12-50

24C. NAME OF CEMETERY OR CREMATORY

Holy Cross Cem

24D. LOCATION (City, town, or county)

Annapolis Blvd Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Washington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John F. Denny, Inc. 715 Light St.

UNITED STATES GOVERNMENT  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
FEDERAL BUREAU OF INVESTIGATION  
OFFICE OF THE ATTORNEY GENERAL  
WASHINGTON, D. C.

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of death: \_\_\_\_\_  
5. Place of death: \_\_\_\_\_  
6. Cause of death: \_\_\_\_\_  
7. Manner of death: \_\_\_\_\_  
8. Signature of physician: \_\_\_\_\_  
9. Signature of registrar: \_\_\_\_\_  
10. Signature of informant: \_\_\_\_\_



50' 6095

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6095  
Registered No. \_\_\_\_\_

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Mr. Charles Fish LaMont		July 11, 1950	
3. PLACE OF DEATH:		4. USUAL RESIDENCE (Where deceased lived. If institution: residence)	
A. Baltimore City, Maryland		A. STATE B. COUNTY before admission)	
B. FULL NAME OF (If not in hospital or institution, give street address or location)		Maryland Baltimore	
HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
St. Joseph's Hospital		Baltimore Co.	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
Yrs. Mos. Days		104 McCormick Avenue 5300	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Male	White	Widowed	Mar. 3, 1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Retired Agent		R. R.	76
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
New York State			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Henry LaMont		Flora Fish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
-		706-10-2501	
17. INFORMANT		ADDRESS	
Mr. George LaMont			

16. <u>581.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH <u>Cirrhosis of liver</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) DUE TO			
		(C) <u>Arteriosclerotic cardiovascular disease</u>			
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/8/</u> , 19 <u>50</u> , to <u>7/11/</u> , 19 <u>50</u> that I last saw the deceased alive on <u>7/11/</u> , 19 <u>50</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.					
23A. SIGNATURE <u>Thaddeus Sawinski</u>		23B. ADDRESS <u>1400 N. Caroline Street</u>		23C. DATE SIGNED <u>7-11-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>7/14/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Honeaye Falls</u>	
				24D. LOCATION (City, town, or county) (State) <u>Honeaye Falls, N. Y.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 12 1950</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>Dr. M. J. Ticker</u>	
				ADDRESS <u>1400 N. Caroline Street</u>	

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70  

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1920

532

50 6096

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6096

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES Edward KOONTZ</b>		2. DATE OF DEATH <b>July 11, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Balto</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Murray Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 20-02</b>			
c. Length of stay in Baltimore <b>75</b> Yrs. <input checked="" type="checkbox"/> Mths. <input checked="" type="checkbox"/> Days		D. STREET ADDRESS (If rural, give location) <b>2535 Edmondson Ave.</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>12/2/75</b>	9. AGE (In years last birthday) <b>74 75</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>mechanic-fare boxes</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Transit</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>John H. Koontz</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-05-9938</b>		17. INFORMANT ADDRESS <b>Mrs. J. A. Reynolds 2506 Arunah Ave.</b>	
18. <b>4/20/11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO		CAUSE OF DEATH <b>Fibrillation</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>3 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION <b>7/13/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 9, 1950</b> , to <b>July 11, 1950</b> , that I last saw the deceased alive on <b>July 11, 1950</b> , and that death occurred at <b>10:00 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Frank G. Kuehn M.D.</b>		23B. ADDRESS <b>Murray Hospital</b>		23C. DATE SIGNED <b>7/11/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/13/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25. FUNERAL DIRECTOR <b>26m. J. Pickner &amp; Sons - Balto Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		ADDRESS <b>94a</b>	

MEDICAL CERTIFICATION



655  
50 6097BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

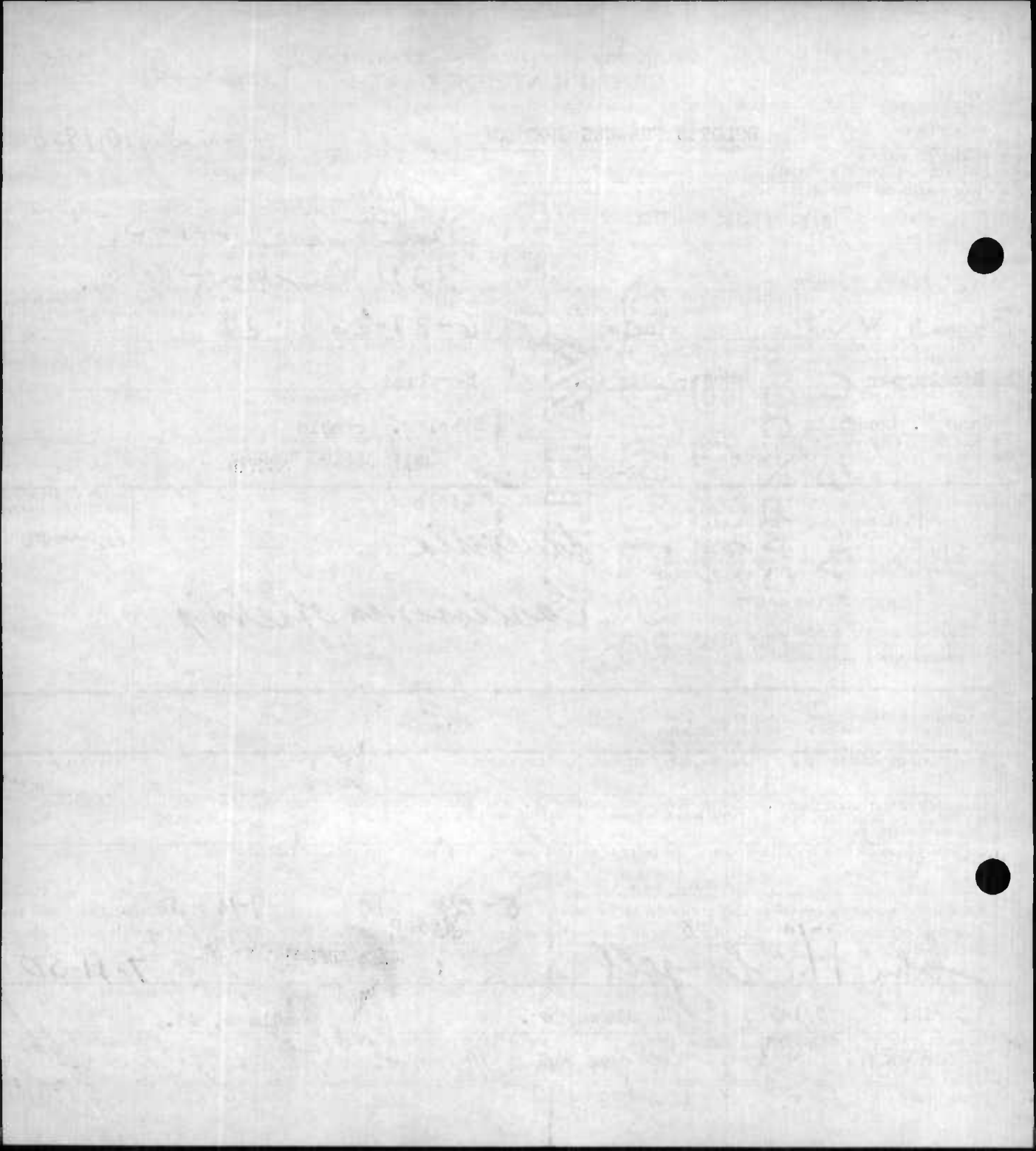
Registered No. 50 6097

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		DOLORES FRANCES SHERMAN		2. DATE OF DEATH July 10, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
b. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-03			
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) 3311 Rueckert Ave.			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH 6-27-26	9. AGE (In years last birthday) 24	10. Under 1 Year Months: Days: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Moss-Rouse Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John F. Loughlin		14. MOTHER'S MAIDEN NAME Ethel M. Trumble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-22-5267		17. INFORMANT JOHNS HOPKINS HOSPITAL	
				ADDRESS	

18.	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) Uremia	6 mos
ANTECEDENT CAUSES	(B) Carcinoma of Cervix	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 6		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) F INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> m. WORK AT WORK	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-24, 1950, to 7-10, 1950, that I last saw the deceased alive on 7-10, 1950, and that death occurred at 6:55 P.m., from the causes and on the date stated above.					
23A. SIGNATURE John H. Angel		23B. ADDRESS JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED 7-11-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/14/50	24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	24D. LOCATION (City, town, or county) (State) Woodlawn, Md.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1950		REGISTRAR'S SIGNATURE Washington Williams, M.D.		25. FUNERAL DIRECTOR Wm. J. Vickner & Sons - Balt 48a Md.	





651  
50 6098BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6098

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)2. DATE  
OF  
DEATH 7/11/50

MARGARET MAY DERRENBERGER

3. PLACE OF DEATH:  
A. Baltimore City, Maryland4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)  
A. STATE Maryland B. COUNTYB. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONC. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)  
Baltimore 15-06

HOSPITAL FOR THE WOMEN of Maryland

D. STREET ADDRESS (If rural, give location)  
2001 Braddish Ave

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years;  
last birthday) 61If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Housewife.10B. KIND OF BUSINESS OR  
INDUSTRY11. BIRTHPLACE (State or foreign country)  
Maryland12. CITIZEN OF  
WHAT COUNTRY?  
USA.

13. FATHER'S NAME

Charles Cortland Conser

14. MOTHER'S MAIDEN NAME  
Mary Twailer15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT ADDRESS Ave.  
Mr. Howard L. Derrenberger-2001 Braddish

18. 162X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Carcinoma Lung, right  
DUE TO pericardium.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Metastatic Carcinoma Liver, pleura, bones?  
DUE TO

(C) Hemopericardium

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/10, 1950 to 7/11, 1950, that I last saw the  
deceased alive on 7/11, 1950, and that death occurred at 4:40 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Mark E. Hall, Jr.

M. D.

Women's Hosp

7/11/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7/14/50

Loudon Park Cem.

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 12 1950

Huntington Williams, M.D.

St. M. J. Tickner &amp; Sons - Balto

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

Twelfth

1910-1911

462

50 6099

CLARK  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6099  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Martha W. Clark

2. DATE  
OF  
DEATH

July 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 15-06

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Bon Secours Hosp.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) 10 Under 1 Year 11 Under 24 Hours

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John F. C. Offutt

14. MOTHER'S MAIDEN NAME

Mary E. ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

none

Mrs. R. M. McGee 3101 Milford Ave.

18. 470.0

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Congestive Heart Failure

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Arteriosclerotic Heart Disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/27/50 19, to 7/11, 1950, that I last saw the deceased alive on 7/11, 1950, and that death occurred at 4:45 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Frank A. Farano M. D.

Bon Secours Hosp.

7/11/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7/13/50

Loudon Park Cem.

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 12 1950

Huntington Williams, M.D.

Wm. J. Tichner &amp; Sons Balto.

VS 150

930

MEDICAL CERTIFICATION

STATE OF NEW YORK  
IN SENATE  
JANUARY 1, 1914.

REPORT

OF THE

COMMISSIONERS

OF THE

LAND OFFICE

FOR THE

YEAR 1913.

ALBANY:

1914.

PRINTED BY

THE STATE

white  
300 50 6100BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6100  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Sarah White</i> / WHITE		2. DATE OF DEATH <i>7/10/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>914 Shields pl</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission): A. STATE <i>md</i> B. COUNTY <i>914 Shields place</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION —		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 17-01</i>	
c. Length of stay in Baltimore <i>27 Yrs</i>		D. STREET ADDRESS (If rural, give location) <i>914 Shields</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>N</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>1923</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>cleaning clothes</i>	
13. FATHER'S NAME <i>Frank White</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Margaret J. White</i>		ADDRESS <i>914 Shields</i>	

18. *002X* I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

DUE TO

(A)

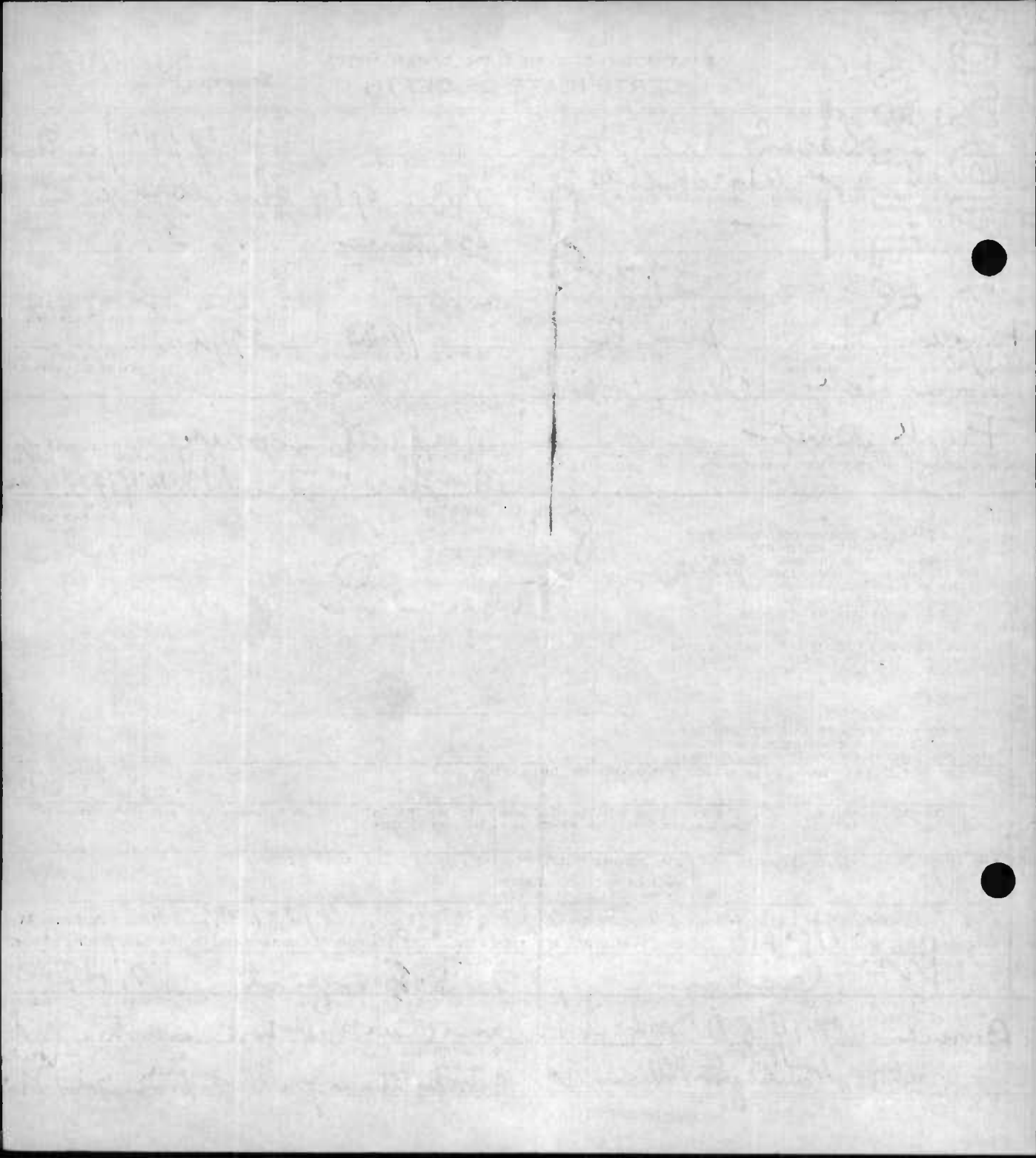
DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

*4 wks*

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6/1/50</i> 19, to <i>7/10/50</i> 19, that I last saw the deceased alive on <i>7/10/50</i> 19, and that death occurred at <i>2:00 PM</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Wm. Carne</i>		23B. ADDRESS <i>253 Gense st</i>		23C. DATE SIGNED <i>7/11/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/14/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>md. Auburn. cem. Westport</i>	
24D. LOCATION (City, town, or county) (State) <i>Balth. md</i>		25. FUNERAL DIRECTOR <i>Metropolitan Funeral Home</i>		ADDRESS <i>927 N. 13B</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 12 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, MD</i>		25. FUNERAL DIRECTOR <i>Metropolitan Funeral Home</i>	





250  
50 6101BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6101  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA JACKSON

2. DATE  
OF  
DEATH

July 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 300 S. Eaton St.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

26-08

D. STREET ADDRESS (If rural, give location)

300 S. Eaton St.

C. Length of stay in Baltimore Lifetime

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE. MARRIED.  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 7, 1897

9. AGE (In years  
last birthday)

53

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Peter Bauernfiend

14. MOTHER'S MAIDEN NAME

Catherine Horn.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.  
None

17. INFORMANT

ADDRESS

Earl L. Jackson 300 S. Eaton St.,

18. 175X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Carcinoma ovary

INTERVAL BETWEEN  
ONSET AND DEATH

6 mos.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO  
(C) .....II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

Feb 1950

19B. MAJOR FINDINGS OF OPERATION

Generalized Carcinomatosis

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 1949 to July 10, 1950 that I last saw the deceased alive on 7-10, 1950. and that death occurred at 1:55 A.M., from the causes and on the date stated above.

23A. SIGNATURE

William L. Fleming

M. D.

23B. ADDRESS

3025 Belair Road

23C. DATE SIGNED

7-10-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 13, 1950

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Parkville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

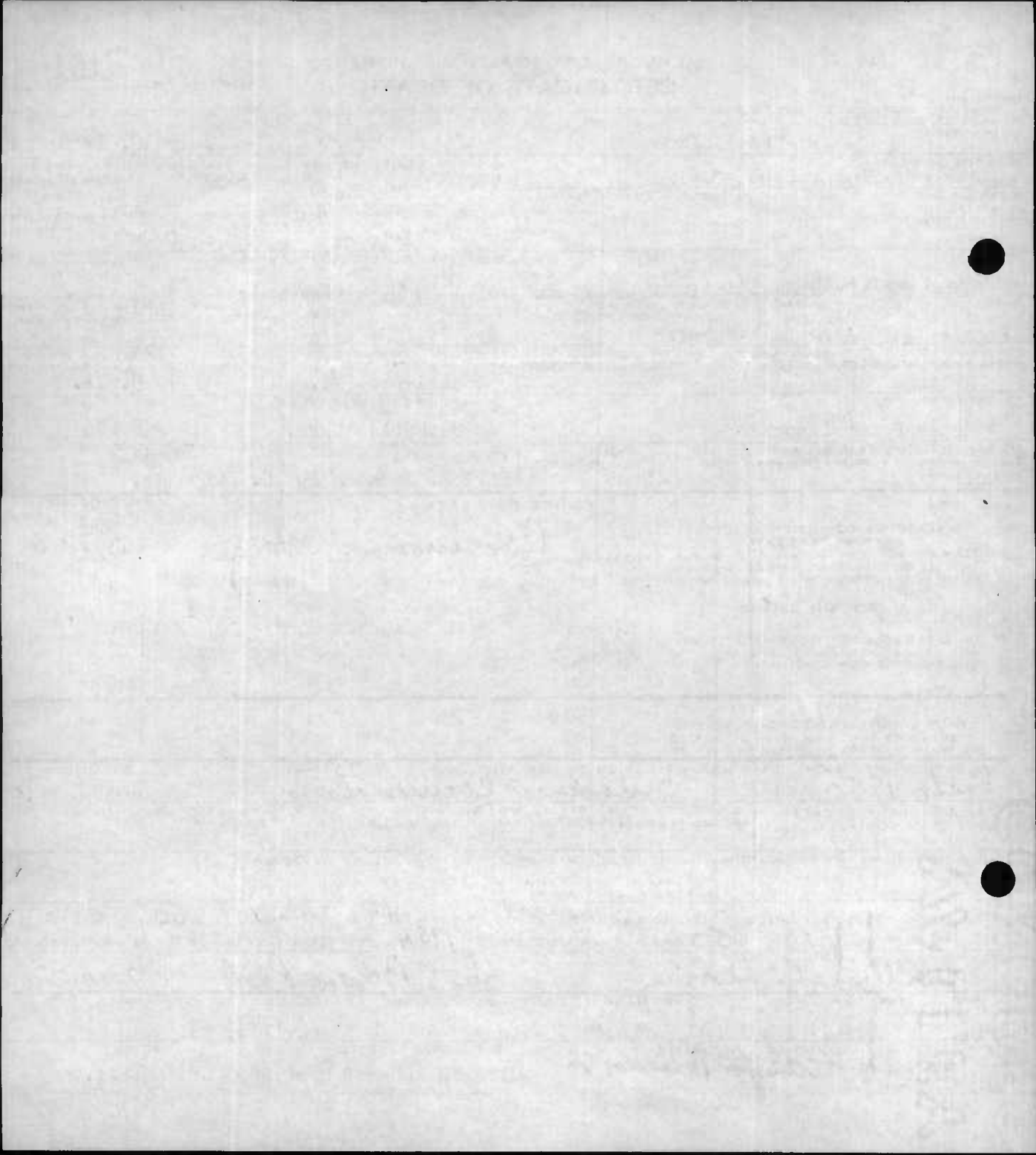
25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2008 Orleans St.,

VS 150

49a



# CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CALVIN CASPER

2. DATE OF DEATH

July 9, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

St. Joseph's Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1108 E. North Avenue

C. Length of stay in Baltimore

life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

student

8. DATE OF BIRTH

March 18, 1938

9. AGE (In years last birthday)

12

If Under 1 Year Months Days

If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School Boy

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frank Casper

14. MOTHER'S MAIDEN NAME

Dorothy Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT ADDRESS

Mrs. Dorothy Mackey (Mother)  
Mrs. Frank Casper 1108 E. North Ave.

18. E813.01

### CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushing injury of the head

DUE TO

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

North Avenue and Broadway

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

July 9, 1950 2.20pm.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Bicycle and truck collision

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

RS Fisher

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

July 10, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 13, 1950

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Colgate, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

JUL 12 1950

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Ullrich Funeral Home 2008 Orleans St.

V S 151

N-803.2

170c

MEDICAL CERTIFICATION



143

50 6103

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6103

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA P. RAPPOLD

2. DATE  
OF  
DEATH

July 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2400 E. Fayette St.,

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

6-02

D. STREET ADDRESS (If rural, give location)

2400 E. Fayette St.,

C. Length of stay in Baltimore 69 Years

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 18, 1860

9. AGE (In years  
last birthday)

90

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Meinhart

14. MOTHER'S MAIDEN NAME

Henrietta Schlegle

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.  
None

17. INFORMANT

ADDRESS

Charles Rappold 3101 Lawnview Ave.,

18. 442X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE. (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

Cardio-Vascular-Renal  
Disease  
Myocardial InsufficiencyINTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 13, 1950, to July 11, 1950, that I last saw the  
deceased alive on July 7, 1950, and that death occurred at 8 A.M., from the causes and on the date stated above.

23A. SIGNATURE

W. G. Geyer

M. O.

23B. ADDRESS

156 H. Milton Ave

23C. DATE SIGNED

7/11/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 14, 1950

24C. NAME OF CEMETERY OR CREMATORY

Parkwood

24D. LOCATION (City, town, or county)

Parkville, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

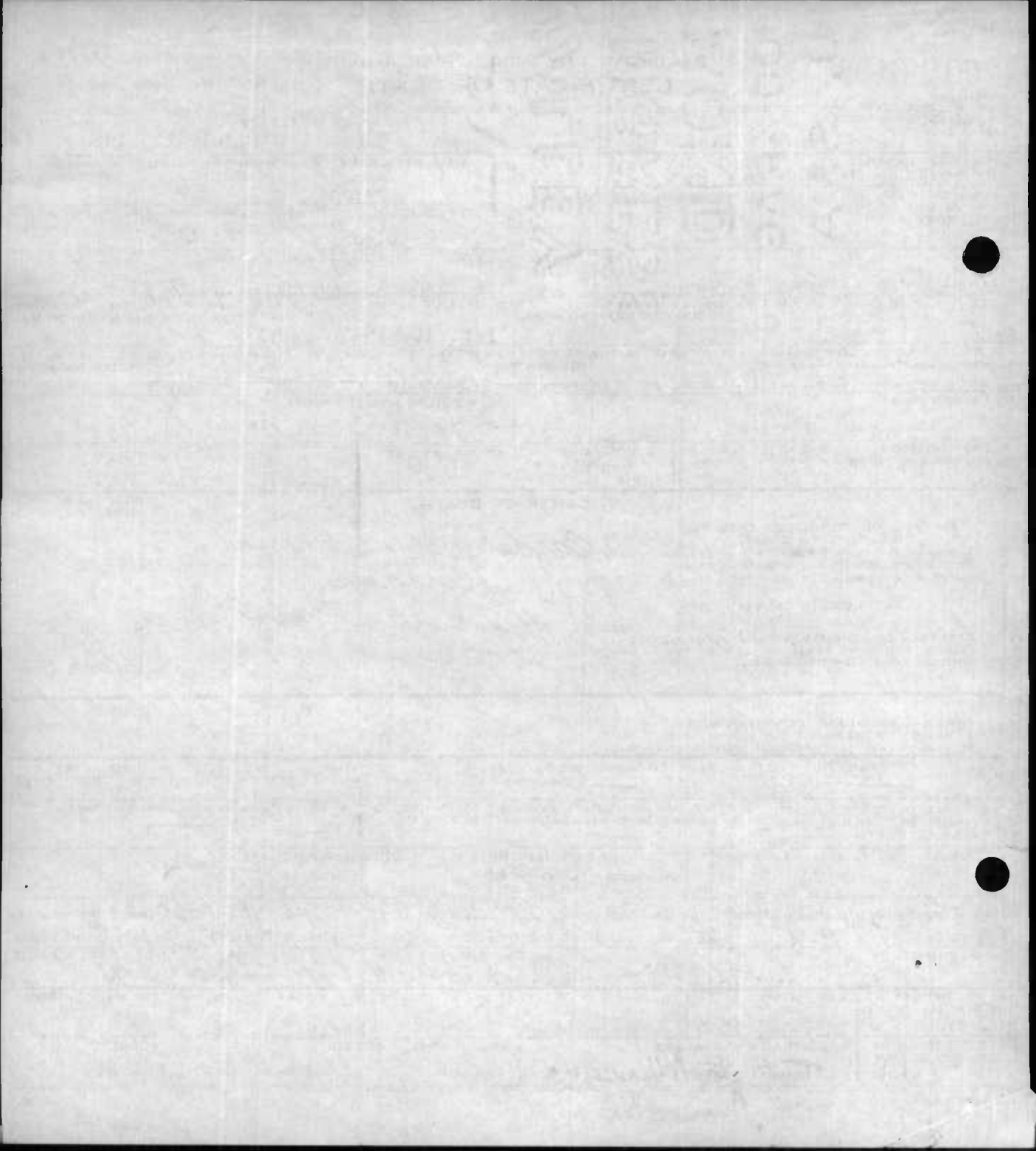
ADDRESS

Ullrich Funeral Home 2008 Orleans St.

VS 150

131a

MEDICAL CERTIFICATION





-650  
50 6104

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6104

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Married Brown</i>		2. DATE OF DEATH <i>July 10, 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) A. STATE <i>Ind.</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore - 16-01</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1203. Dashed St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>5-23-12</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, e.g. if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>38 yrs</i>
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Mr. Brown</i>		14. MOTHER'S MAIDEN NAME <i>Mr. Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>		ADDRESS	

18. <i>600.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Pyelonephritis with uremia</i>	CAUSE OF DEATH (A) <i>Chronic Pyelonephritis with uremia</i> DUE TO (B) <i>Hypertensive cardiovascular disease</i> DUE TO (C) <i>Congenital B. double renal pelvis &amp; ureters</i>	INTERVAL BETWEEN ONSET AND DEATH <i>? 15 YRS</i> <i>? 10 YRS</i> <i>38 YRS</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION <i>None</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Apr. 20, 1950</i> to <i>July 10, 1950</i> that I last saw the deceased alive on <i>July 10, 1950</i> and that death occurred at <i>1:40 P.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Thomas E. Van Metre</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>10 July 50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-14-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md</i>		24E. FUNERAL DIRECTOR <i>Huntington Williams, Jr.</i>		24F. ADDRESS <i>578 W. Mrs. Frances A. Humbley Biddle St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 12 1950</i>		VS 150			

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24p215      then it's important to note  
 24p015      the literature (and the literature)  
 24p285      lower than the other (and the other)

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NAME —————

NAME —————

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Thomas E. Van Meter

200  
REA-138592BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6105  
Registered No.

BIRTH NO. 50 6105

1. NAME OF DECEASED (Type or Print) <b>LaFayette Tawes</b>		2. DATE OF DEATH <b>July 11, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>11-03</b>	
c. Length of stay in Baltimore <b>25 yrs.</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>846 N. Eutaw Street (1)</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 13, 1878</b>
9. AGE (In years last birthday) <b>71</b>		10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bundle Sorter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chito Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Dele Island and</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>214-23-0977</b>	
17. INFORMANT <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		ADDRESS	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Pulmonary Edema (Cardiac Hypertrophy)</b> DUE TO (B) <b>Coronary Arteriosclerosis</b> DUE TO (C) <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>7/13/50</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 4</b> , 1950, to <b>July 11</b> , 1950, that I last saw the deceased alive on <b>July 11, 1950</b> , and that death occurred at <b>12:40 A. M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>W. S. Boyer</b>		23B. ADDRESS <b>M. D. 4940 Eastern Avenue</b>	
23C. DATE SIGNED <b>7-11-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/13/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mount Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Belair Rd</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
FUNERAL DIRECTOR <b>Chas P. Howell</b>		ADDRESS <b>2447 Edmondson Ave</b>	

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50 6106

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6106

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annie C. Holmes

2. DATE  
OF  
DEATH

July 10 - 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Maryland

B. COUNTY

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

5017 E. Preston Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 26-44

D. STREET ADDRESS (If rural, give location)

5017 E. Preston Street

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days  
11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 592X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) DUE TO

(B) DUE TO

(C)

Cerebral Thrombosis

Artero-sclerosis

Chronic anemia

Chronic nephritis

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

M.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from May 1, 1950, to July 10, 1950, that I last saw the  
deceased alive on July 5, 1950, and that death occurred at 5 m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 12 1950

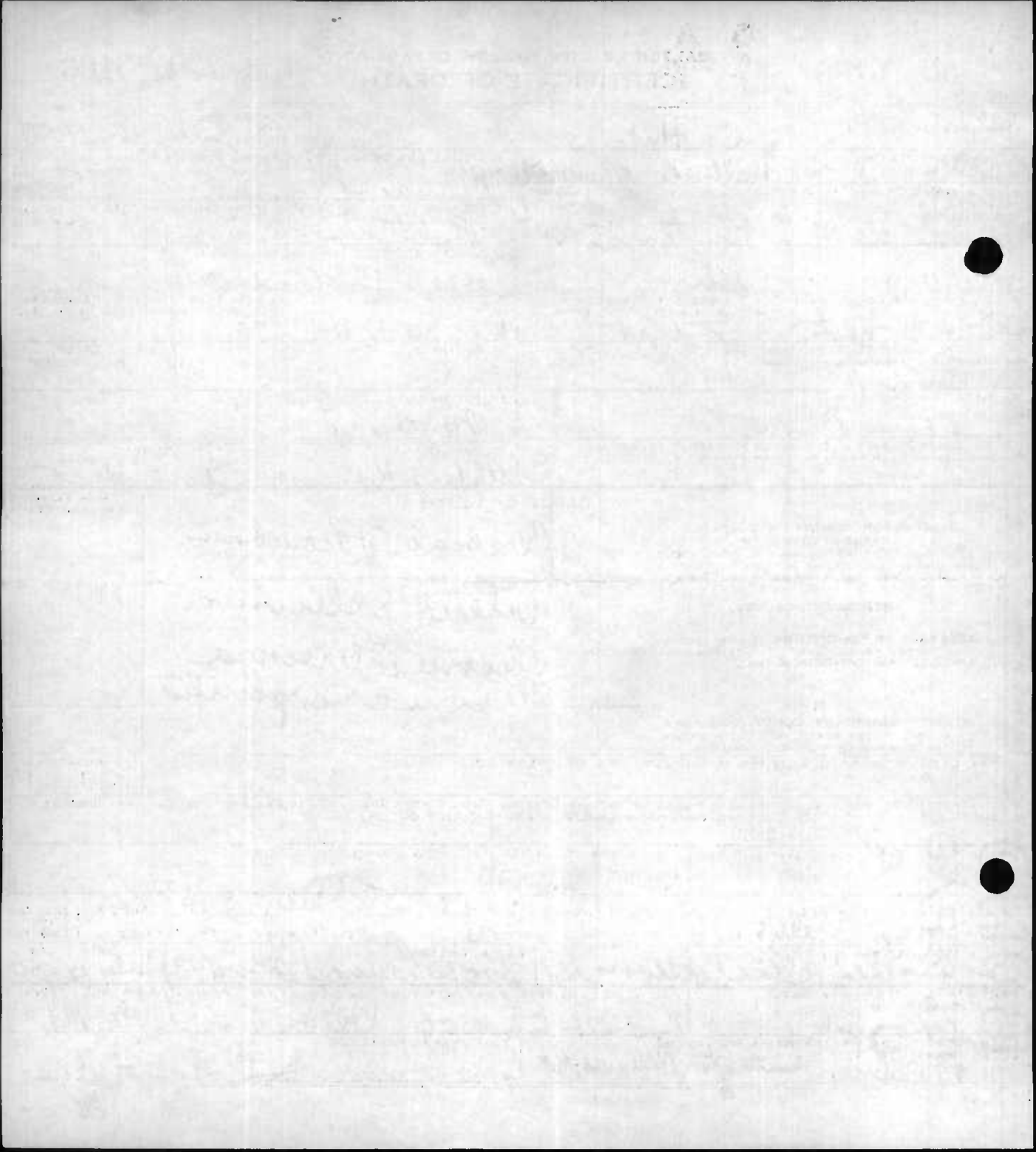
Huntington Williams, M.D.

Joseph J. Jansse, Inc. 2013  
Shannon Drive, Balto, Md.

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MEDICAL CERTIFICATION





-400  
50 6107BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>BERTRAM I. WEIL</b>			2. DATE OF DEATH <b>7-11-50</b>																										
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>New York</b> B. COUNTY <b>V-29</b>																													
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Southern Hotel</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>New York City</b>																													
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>360 Central Park West</b>																													
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>57</b>		9. AGE (In years last birthday) <b>57</b>		10. Under 1 Year Months: Days		11. Under 24 Hours Hours: Min.																				
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>President</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Jameson Lumber Co</b>			11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>			12. CITIZEN OF WHAT COUNTRY?																							
13. FATHER'S NAME <b>Benjamin</b>			14. MOTHER'S MAIDEN NAME <b>not known</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Gertrude Weil</b> ADDRESS <b>same</b>																				
18. <b>4201</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH						INTERVAL BETWEEN ONSET AND DEATH																							
ANTECEDENT CAUSES			(A) <b>Coronary occlusion</b> DUE TO						<b>24 hrs</b>																							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) <b>hypertension +</b> DUE TO						<b>3 mo</b>																							
II			(C) <b>Arteriosclerosis</b>						<b>3 mo</b>																							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			19A. DATE OF OPERATION <b>0</b>						19B. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME (Month) (Day) (Year) (Hour) INJURY						21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK						21F. HOW DID INJURY OCCUR?											
22. I hereby certify that I attended the deceased from <b>7-10</b> , 19 <b>50</b> to <b>7-11</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7-11</b> , 19 <b>50</b> , and that death occurred at <b>9A</b> m., from the causes and on the date stated above.															23A. SIGNATURE <b>Dr. Min. Kambes</b> M. D.						23B. ADDRESS <b>3003 J. J. Williams, Md</b>						23C. DATE SIGNED <b>7-11-50</b>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			24B. DATE <b>7-13-50</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Herrington</b>			24D. LOCATION (city, town, or county) (State) <b>Balto Md</b>																							
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>			REGISTRAR'S SIGNATURE <b>Washington Williams, Md</b>			25. FUNERAL DIRECTOR <b>Jack Lewis</b>			ADDRESS <b>2100 Central Pl</b>																							

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50 6108

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6108

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clara E. Mantler

2. DATE  
OF  
DEATH

7-9-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION 1718 Darley Avenue4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE Md B. COUNTY before admission)C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
Baltimore Md. 8-05 township)

D. STREET ADDRESS (If rural, give location)

1718 Darley Avenue

c. Length of stay in Baltimore

65 yrs

Yrs.  
Mos.  
Days

5. SEX

F.

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

11-26-70

9. AGE (In years  
last birthday)

79

10. Under 1 Year  
Months: Days  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
Housewife10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?  
USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Chas. C. Mantle- 1718 Darley Ave.

18. 422.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

2 wks.

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT

WORK

NOT WHILE

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 18, 1950, to July 9, 1950, that I last saw the  
deceased alive on July 8, 1950, and that death occurred at 7:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-12-50

24C. NAME OF CEMETERY OR CREMATORY

St, Mary's

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 12 1950

Huntington Williams, M.D.

Lilly &amp; Zeiler Inc., 403 S. Wolfe Street

VS 150

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1331 E. North Ave.

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P-120-5-77  
50 6109BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6109  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>VERNON A. PHIPPS</b>		2. DATE OF DEATH <b>7/10/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>6200</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE A.A. #25</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSP.</b>		D. STREET ADDRESS (If rural, give location) <b>206 ARUNDEL ROAD A.A.</b>		5. LENGTH OF STAY IN BALTIMORE <b>4 Yrs. Mos. Days</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W.</b>	B. DATE OF BIRTH <b>6 July 1884</b>	9. AGE (In years last birthday) <b>66</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>TOBACCO DEALER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ANDREW PHIPPS</b>		14. MOTHER'S MAIDEN NAME <b>MARY V. EVANS</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family - Same</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Complete heart block</b>		CAUSE OF DEATH (A) <b>Complete heart block</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>several years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic C-V disease</b>		(B) <b>Arteriosclerotic C-V disease</b> DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Coronary heart failure</b>		(C) <b>Coronary heart failure</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-4</b> , 19 <b>50</b> , to <b>7-10</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-10</b> , 19 <b>50</b> , and that death occurred at <b>6 A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Allyn F. Judd</b>		23B. ADDRESS <b>Mercy Hospital</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B.</b>		24B. DATE <b>7-11-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	
24D. LOCATION (City, town, or county) <b>Glen Haven</b>		24E. STATE <b>Baltimore</b>		24F. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>	
24G. REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		24H. FUNERAL DIRECTOR <b>James L. McCreary</b>		24I. ADDRESS <b>2906A - 30 E. TOWNT AVE.</b>	

CERTIFICATE OF DEATH

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6110**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Durbin D. PARKS** 2. DATE OF DEATH **July 11, 1950**

3. PLACE OF DEATH:  
a. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE **Maryland** b. COUNTY **Baltimore**

b. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION **Union Memorial Hospital** c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

d. STREET ADDRESS (If rural, give location)  
**1752 Forrest Avenue** 5. SEX **Male** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **married** 8. DATE OF BIRTH **July 5-1904** 9. AGE (in years last birthday) **46** 10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min.

c. Length of stay in Baltimore **Yrs. Mos. Days** 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Plastering Contractor** 10b. KIND OF BUSINESS OR INDUSTRY **Baltimore Md** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Howard Parks** 14. MOTHER'S MAIDEN NAME **Alberta Poe**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **Mrs. Hazel Parks-1752 Forrest Ave.** ADDRESS

18. **420.1** CAUSE OF DEATH **Coronary thrombosis** INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) **Coronary thrombosis**  
DUE TO

ANTECEDENT CAUSES  
(B) **DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**  
DUE TO

(C) **OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 21e. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK AT WORK 21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE **R S Fisher** 23b. CHIEF MEDICAL EXAMINER.....☒ M.D. MEDICAL INVESTIGATOR.....☐ 23c. DATE SIGNED **July 11, 1950**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **7/14/50** 24c. NAME OF CEMETERY OR CREMATORY **Mayes Chapel** 24d. LOCATION (City, town, or county) (State) **Towson Md**

DATE RECEIVED BY LOCAL REGISTRAR **Huntington Williams** REGISTRAR'S SIGNATURE **L. J. Luck** 25. FUNERAL DIRECTOR **5305 Harford Rd** ADDRESS

V S 151 **1111** 12 1950 **29024** **994a** ✓

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

DATE OF DEATH

415  
50 6111

ALBAN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6111  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **FRANCIS A. ALBAN**

2. DATE OF DEATH **JULY 11, '50**

3. PLACE OF DEATH:  
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**UNIVERSITY HOSP**

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
a. STATE **MARYLAND**  
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**BALTIMORE 9-67**

d. STREET ADDRESS (If rural, give location)  
**1525 Caranell Street**

5. SEX **M** 6. COLOR OR RACE **W** 7. SINGLE ☒ MARRIED ☒ WIDOWED ☐ DIVORCED (Specify) **married**

8. DATE OF BIRTH **May 21-1901** 9. AGE (In years last birthday) **49** 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Salesman**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)  
**Baltimore Md**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
**George N. Alban**

14. MOTHER'S MAIDEN NAME  
**Ella A. Mulligan**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or no, down) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Mrs. Jessie Alban - 1525 Caranell**

18. **540.0 I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **PNEUMONIA** DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Sub. DIAPHRAGMATIC ABSCESS** DUE TO

(C) **BLEEDING PEPTIC ULCER**

INTERVAL BETWEEN ONSET AND DEATH **40 days**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **5-29-50** 19B. MAJOR FINDINGS OF OPERATION **PEPTIC ULCER** 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **JULY 1**, 1950, to **JULY 11**, 1950, that I last saw the deceased alive on **JULY 11**, 1950, and that death occurred at **500 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE **Edmund B Middleton** M. D. 23B. ADDRESS **University Hospital** 23C. DATE SIGNED **July 11, 50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7-15-50** 24C. NAME OF CEMETERY OR CREMATORY **New Cathedral Balto. Md** 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR **JUL 12 1950** REGISTRAR'S SIGNATURE **Wm. J. Williams** 25. FUNERAL DIRECTOR **L. J. Luck** ADDRESS **5305 Hayford Rd.**

VS 150

MEDICAL CERTIFICATION

117a

A. 1891

Amount

1891-1892

1892-1893

1893-1894

1894-1895

1895-1896

1896-1897

1897-1898

1898-1899

1899-1900

1900-1901

1901-1902

1902-1903

1903-1904

1904-1905

1905-1906

1906-1907

1907-1908

1908-1909

536  
50 6112BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6112  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HARRY LIVINGSTON HENDERSON

2. DATE  
OF  
DEATH

7-10-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

Life

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug. 4, 1902

9. AGE (In years  
last birthday)

47

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

self emp.

H.S.

10B. KIND OF BUSINESS OR  
INDUSTRY

Transportation Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles L. Henderson

14. MOTHER'S MAIDEN NAME

Ida Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

YES

(If yes, give war or dates of service)

WW1 &amp; WW2

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT  
ADDRESSMrs. Evelyn B. Henderson  
4635 Harcourt Road

18. 443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral hemorrhage (left)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertensive Cardiovascular Disease

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-10-50, 19\_\_, to 7-10-50, 19\_\_, that I last saw the  
deceased alive on 7-10-50, 19\_\_, and that death occurred at \_\_ m., from the causes and on the date stated above.

23. SIGNATURE

Richard Beach

M. D.

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

7-11-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7/14/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER &amp; SONS, INC.

ADDRESS

BALTIMORE - 13, MD. Beach &amp; Sons

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

MEMORANDUM FOR THE DIRECTOR

SUBJECT: [Illegible]

DATE: [Illegible]

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B-420  
50 6113  
BIRTH NO. 50-14044

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6113  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Blake</b>			2. DATE OF DEATH <b>7-12-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto, Md.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Maryland Gen. Hosp. Balto., Md.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. 8-03</b>		
C. Length of stay in Baltimore <b>35 min</b>			D. STREET ADDRESS (If rural, give location) <b>2805 E. Sadler St</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7-12-50</b>	9. AGE (In years last birthday) <b>35 min</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min. <b>35</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John M. Blake</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			14. MOTHER'S MAIDEN NAME <b>Phyllis M. Valentin</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mother</b> ADDRESS <b>2805 E. Sadler, Balto, Md</b>		

18. <b>251X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Hydrocephalus</b> DUE TO <b>(B) Meningocele</b> DUE TO <b>(C) Deformed left foot</b>		INTERVAL BETWEEN ONSET AND DEATH <b>At Birth</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7-12-50 3</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **7-12**, 19**50**, to **7-12**, 19**50**, that I last saw the deceased alive on **7-12**, 19**50**, and that death occurred at **4:08** m., from the causes and on the date stated above.

23A. SIGNATURE **William F. Barr** M. D. 23B. ADDRESS **Maryland Gen. Hosp.** 23C. DATE SIGNED **7-12-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>7-12-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. Cook Inc 1317 St. Paul #2</b>

VS 150  
JUL 12 1950

157a

10-10-10

Dear Sir,  
I have the pleasure to inform you that  
the same has been received and  
is being forwarded to you by  
the same carrier as the  
other parcels.

Very respectfully,  
Your obedient servant,  
J. H. [Name]

Enclosed for you are  
the same as before.

I am, Sir, very  
truly,  
Your obedient servant,  
J. H. [Name]

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED

(Type or Print)

FRANCES

EKIELSKA

2. DATE

OF  
DEATH

July 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1747 E. Pratt Street

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

March

9. AGE (In years last birthday)

64

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10B. KIND OF BUSINESS OR INDUSTRY

at Home

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Robert L. Lavinowski

14. MOTHER'S MAIDEN NAME

Yank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT

ADDRESS

Feliza Ekielski 1747 E. Pratt St

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary insufficiency

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture of 5th cervical vertebra

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

1747 E. Pratt Street

21D. TIME (Month) (Day) (Year) (Hour) INJURY

July 10, 1950 4:50 P.

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down stairs

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. Fisher

23B. CHIEF MEDICAL EXAMINER.....

ASSISTANT MEDICAL EXAMINER.....

M.D. MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

July 11, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 13/50

24C. NAME OF CEMETERY OR CREMATORY

Interment of Mary Ballman

24D. LOCATION (City, town, or county)

Baltimore

(State)

DATE RECEIVED BY LOCAL REGISTRAR

July 12 1950

REGISTRAR'S SIGNATURE

William Williams

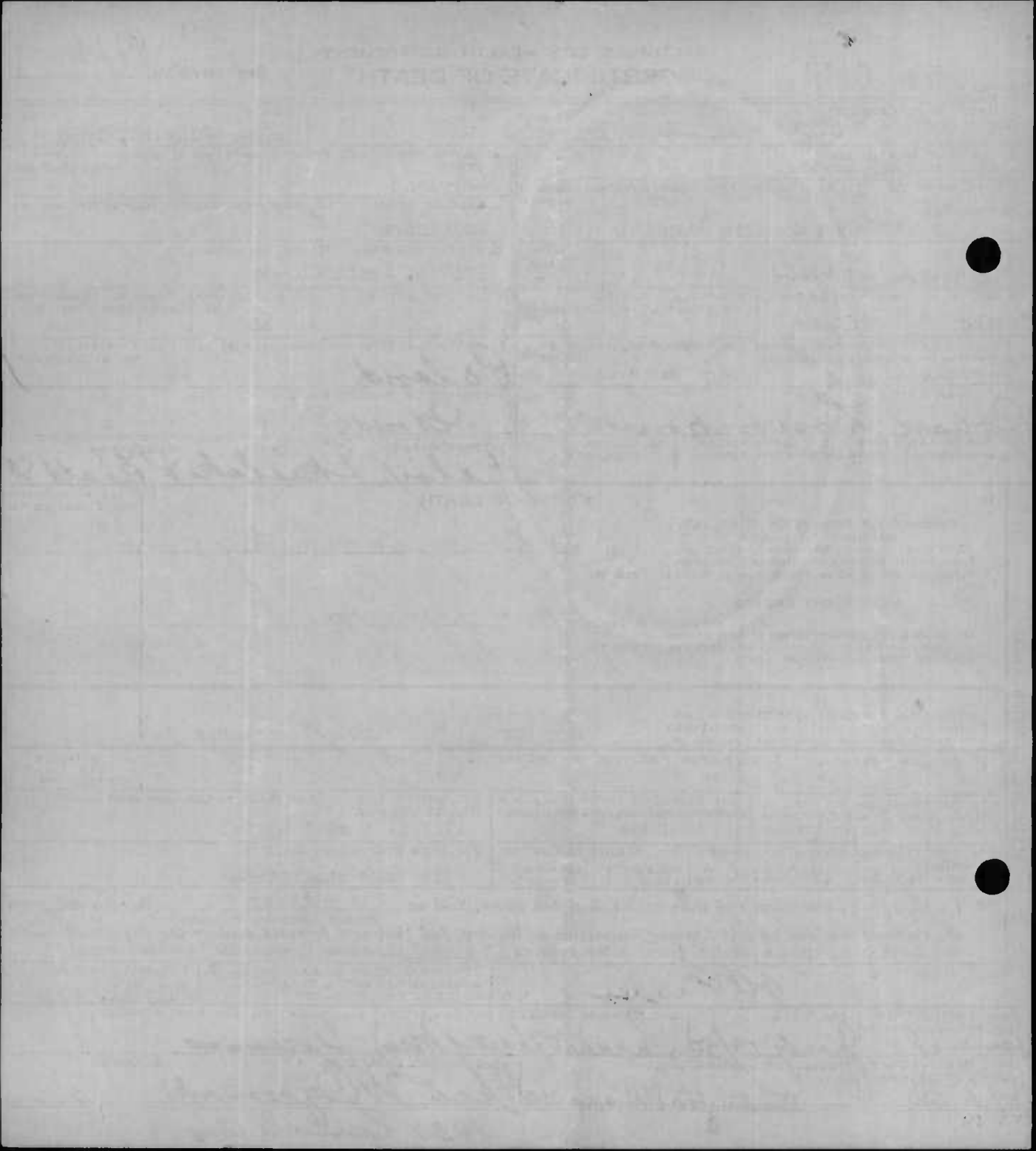
25. FUNERAL DIRECTOR

Fred W. Ozazewski

ADDRESS

1930 Eastern Ave

93D



R-562  
50 6115  
BIRTH NO. 50-14070

Baltimore City Health Department  
CERTIFICATE OF DEATH

50 6115  
Registered No.

Ramirez

1. NAME OF DECEASED (Type or Print) Baby Boy RAMIREZ		2. DATE OF DEATH 7/11/50.	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY	
B. Full Name of Hospital or Institution (If not in hospital or institution, give street address or location) Mercy Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore MD.	
D. STREET ADDRESS (If rural, give location) 1338 S. Harwood			
c. Length of stay in Baltimore 1 Yrs. Mos. Days			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) infant	8. DATE OF BIRTH July 10, 1950
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Rusecio Ramirez		12. CITIZEN OF WHAT COUNTRY? US	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS Mazmi Wright	

MEDICAL CERTIFICATION

18. 776X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO CAUSE OF DEATH Pneumat enter INTERVAL BETWEEN ONSET AND DEATH 28 Hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO			
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 10, 1950, July 11, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 1:30 AM., from the causes and on the date stated above.			
23A. SIGNATURE M. E. Matthes		23B. ADDRESS M. E. Matthes	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-12-50	
24C. NAME OF CEMETERY OR CREMATORY Loured Heart		24D. LOCATION (City, town, or county) (State) German Hill Rd	
DATE RECEIVED BY LOCAL REGISTRAR JUL 12 1950		REGISTRAR'S SIGNATURE Wm. Williams	
25. FUNERAL DIRECTOR J. J. Fahey & Sons		ADDRESS 1318 Light St	

159

INVESTIGATION OF DEATH

1. Name of deceased: [illegible]  
2. Age: [illegible]  
3. Sex: [illegible]  
4. Date of death: [illegible]  
5. Place of death: [illegible]  
6. Cause of death: [illegible]  
7. Manner of death: [illegible]  
8. Name of physician: [illegible]  
9. Name of coroner: [illegible]  
10. Name of investigator: [illegible]  
11. Name of witness: [illegible]  
12. Name of jury: [illegible]  
13. Name of judge: [illegible]  
14. Name of jury: [illegible]  
15. Name of judge: [illegible]  
16. Name of jury: [illegible]  
17. Name of judge: [illegible]  
18. Name of jury: [illegible]  
19. Name of judge: [illegible]  
20. Name of jury: [illegible]  
21. Name of judge: [illegible]  
22. Name of jury: [illegible]  
23. Name of judge: [illegible]  
24. Name of jury: [illegible]  
25. Name of judge: [illegible]  
26. Name of jury: [illegible]  
27. Name of judge: [illegible]  
28. Name of jury: [illegible]  
29. Name of judge: [illegible]  
30. Name of jury: [illegible]  
31. Name of judge: [illegible]  
32. Name of jury: [illegible]  
33. Name of judge: [illegible]  
34. Name of jury: [illegible]  
35. Name of judge: [illegible]  
36. Name of jury: [illegible]  
37. Name of judge: [illegible]  
38. Name of jury: [illegible]  
39. Name of judge: [illegible]  
40. Name of jury: [illegible]  
41. Name of judge: [illegible]  
42. Name of jury: [illegible]  
43. Name of judge: [illegible]  
44. Name of jury: [illegible]  
45. Name of judge: [illegible]  
46. Name of jury: [illegible]  
47. Name of judge: [illegible]  
48. Name of jury: [illegible]  
49. Name of judge: [illegible]  
50. Name of jury: [illegible]  
51. Name of judge: [illegible]  
52. Name of jury: [illegible]  
53. Name of judge: [illegible]  
54. Name of jury: [illegible]  
55. Name of judge: [illegible]  
56. Name of jury: [illegible]  
57. Name of judge: [illegible]  
58. Name of jury: [illegible]  
59. Name of judge: [illegible]  
60. Name of jury: [illegible]  
61. Name of judge: [illegible]  
62. Name of jury: [illegible]  
63. Name of judge: [illegible]  
64. Name of jury: [illegible]  
65. Name of judge: [illegible]  
66. Name of jury: [illegible]  
67. Name of judge: [illegible]  
68. Name of jury: [illegible]  
69. Name of judge: [illegible]  
70. Name of jury: [illegible]  
71. Name of judge: [illegible]  
72. Name of jury: [illegible]  
73. Name of judge: [illegible]  
74. Name of jury: [illegible]  
75. Name of judge: [illegible]  
76. Name of jury: [illegible]  
77. Name of judge: [illegible]  
78. Name of jury: [illegible]  
79. Name of judge: [illegible]  
80. Name of jury: [illegible]  
81. Name of judge: [illegible]  
82. Name of jury: [illegible]  
83. Name of judge: [illegible]  
84. Name of jury: [illegible]  
85. Name of judge: [illegible]  
86. Name of jury: [illegible]  
87. Name of judge: [illegible]  
88. Name of jury: [illegible]  
89. Name of judge: [illegible]  
90. Name of jury: [illegible]  
91. Name of judge: [illegible]  
92. Name of jury: [illegible]  
93. Name of judge: [illegible]  
94. Name of jury: [illegible]  
95. Name of judge: [illegible]  
96. Name of jury: [illegible]  
97. Name of judge: [illegible]  
98. Name of jury: [illegible]  
99. Name of judge: [illegible]  
100. Name of jury: [illegible]



W-452  
50 6116BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6116  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Kelly Louis Williams

2. DATE  
OF  
DEATH

July -10-1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 655 W Conway

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

655 W Conway

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 22-02

D. STREET ADDRESS (If rural, give location)

C. Length of stay in Baltimore

11

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

Col

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug 12 1904 45 46

9. AGE (In years  
last birthday)10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Rtg 9th - Pkt Driving Waterfords

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

James Filmore

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Emma Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
183-12-4242

17. INFORMANT

ADDRESS

Edith Lloyd 655 W Conway

18. 331X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Cerebral Hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

23 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Hypertension Arteriosclerosis

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 15, 1950, to July 10, 1950, that I last saw the deceased alive on July 10, 1950 and that death occurred at 5:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)  
(State)DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

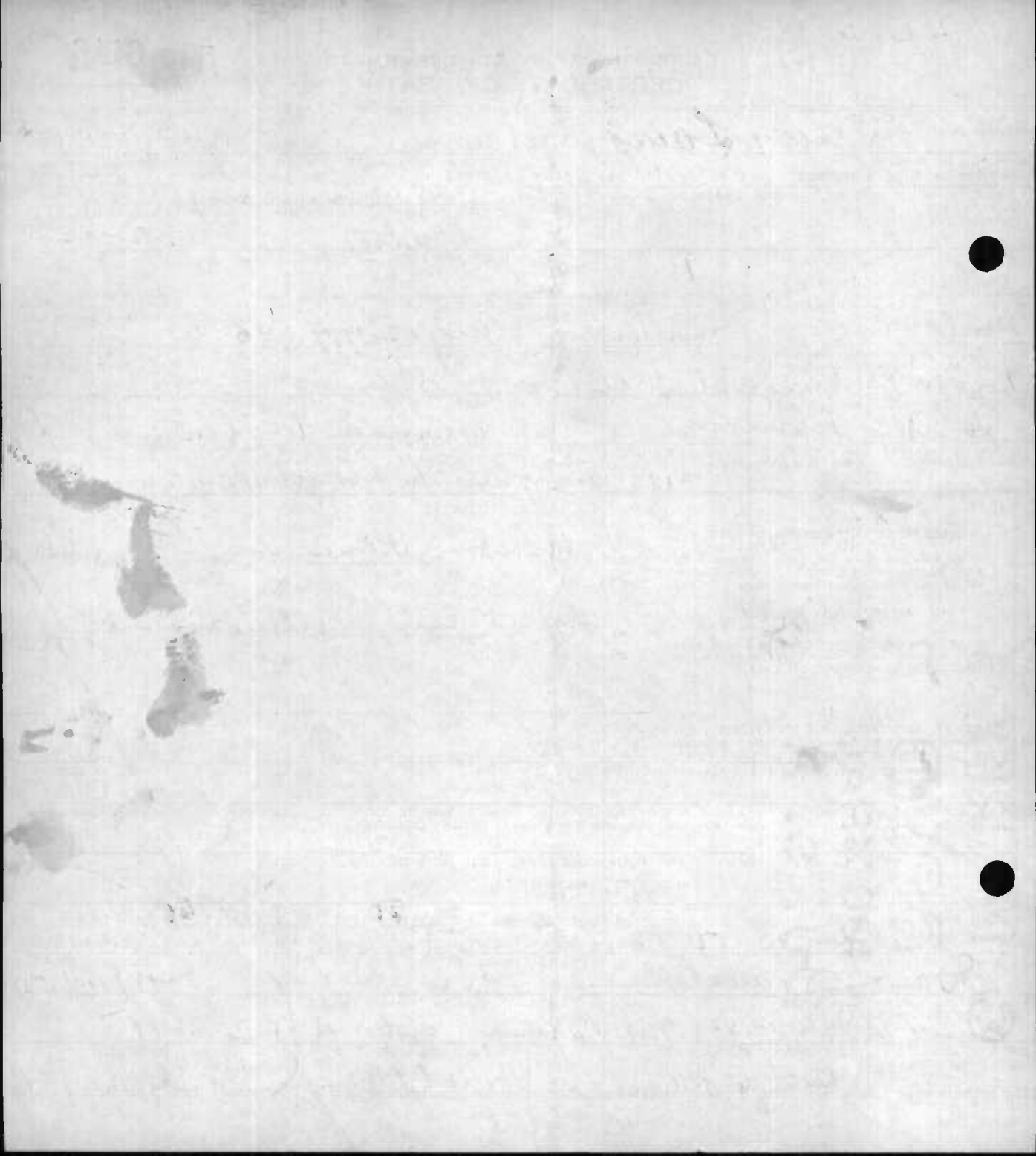
ADDRESS

JUL 12 1950

VS 150

59455

83a.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6117  
Registered No. \_\_\_\_\_

BIRTH NO. 50 6117

1. NAME OF DECEASED (Type or Print) <b>Jerry Satchell</b>		2. DATE OF DEATH <b>7/9/1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>738 George St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore City 17-03</b>	
c. Length of stay in Baltimore <b>40 Yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>738 George Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>11/5/1897</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Skill Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>In General</b>	9. AGE (in years last birthday) <b>52</b>
13. FATHER'S NAME <b>George Satchell</b>		11. BIRTHPLACE (State or foreign country) <b>Eastville Virginia</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME <b>Mary Frances</b>	
17. INFORMANT <b>Jannie Satchell</b>		ADDRESS <b>738 George St</b>	

18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Stomach</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx 6 months</b>
(A) DUE TO _____		
(B) DUE TO _____		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.		

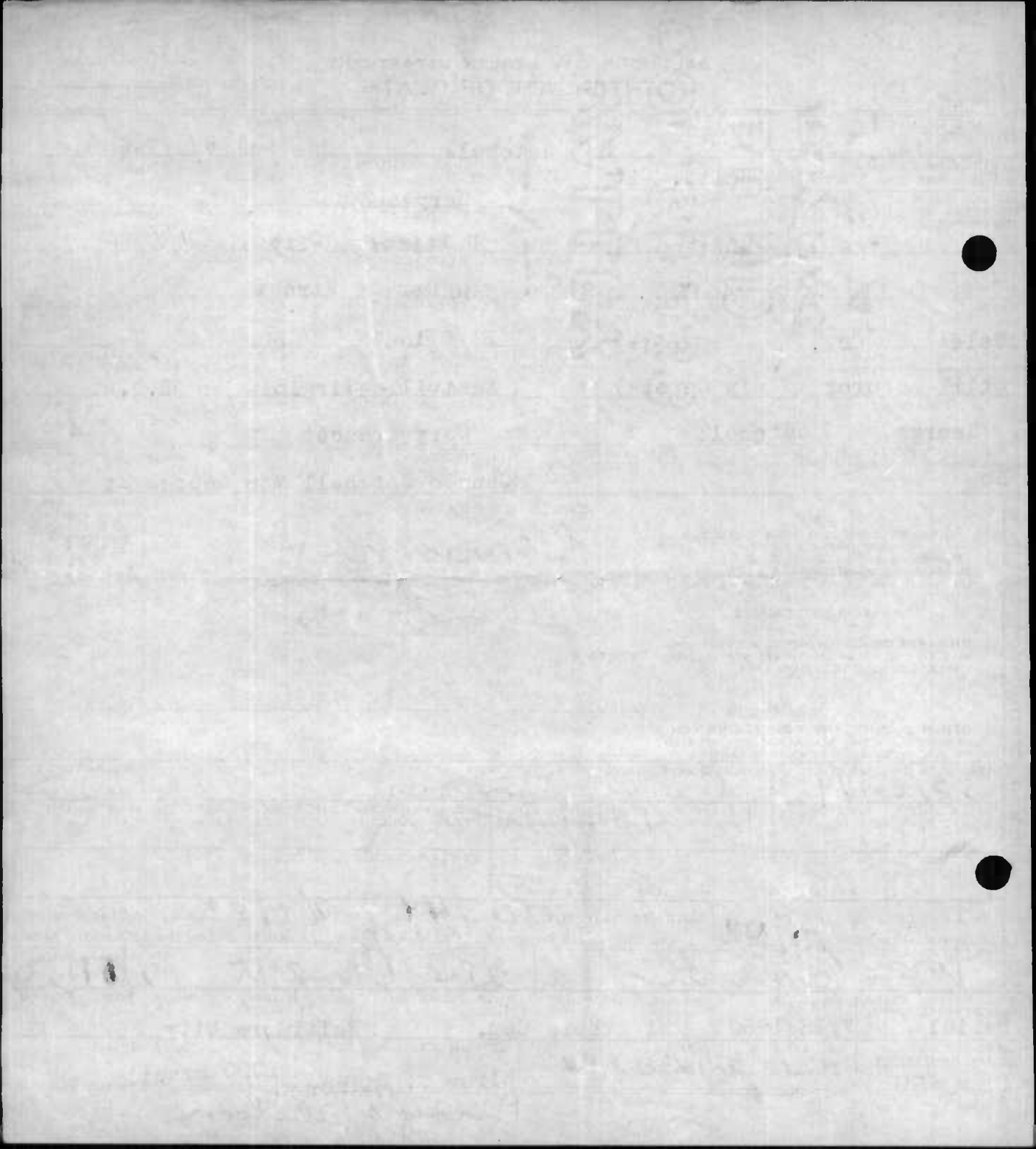
19A. DATE OF OPERATION <b>2/20/49</b>		19B. MAJOR FINDINGS OF OPERATION <b>Cancer of Stomach</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **12/1/49** to **7/9/50**, 19\_\_, that I last saw the deceased alive on **7/9/50**, and that death occurred at **1230 AM** from the causes and on the date stated above.

23A. SIGNATURE <b>Wm Garner</b>	23B. ADDRESS <b>253 George St</b>	23C. DATE SIGNED <b>7/11/50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/13/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Arburn Cem.</b>
24D. LOCATION (City, town, or county) <b>Baltimore City</b>		24E. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>

DATE RECEIVED BY LOCAL REGISTRAR **12/2/1950**  
 REGISTRAR'S SIGNATURE **Wm Garner**  
 ADDRESS **1000 Brantly Ave**  
**970 99 Elroy O. Wilson 46B**

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6118  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>BERNICE JOHNSON</b>			2. DATE OF DEATH <b>July 9, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Johns Hopkins Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>6-04</b>		
5. Length of stay in Baltimore <b>21 Yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>417 N. Ann Street</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6/19/1927</b>		9. AGE (in years last birthday) <b>23</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Norfolk Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Solmon L. Banks</b>			14. MOTHER'S MAIDEN NAME <b>Helen Jenkins</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Helen Jenkins 417 N. Ann St</b>		

18. <b>E982X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>Multiple stab wound of chest, neck, and back</b>  ANTECEDENT CAUSES  <b>Laceration of heart</b>  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.	CAUSE OF DEATH  INTERVAL BETWEEN ONSET AND DEATH
--	--

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIB- UTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Ann Street near Orleans Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 9, 1950 9:15 P.m.</b>		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>She was stabbed in the chest</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Stanley H. Decker</b> M.D.		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 10, 1950</b>	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/13/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Brooklyn A.A.Co.MD</b>		24E. FUNERAL DIRECTOR <b>Elroy O. Wilson 1000 Brantly Ave</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>		REGISTRAR'S SIGNATURE <b>Elroy O. Wilson</b>			

MEDICAL CERTIFICATION





M-635

CERTIFICATE CORRECTED

7-18-50

50 6119

50 6119

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Gladys H. Martini

2. DATE  
OF  
DEATH

7-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Md.

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Sinai Hospital

C. CITY OR TOWN

Balto

(If outside corporate limits, write RURAL and give township)

10-02

D. STREET ADDRESS (If rural, give location)

815 Mc Kim St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

7.

6. COLOR OR RACE

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6/7/29 1919

9. AGE (In years last birthday)

31

11 Under 1 Year Months: Days

12 Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Finch

14. MOTHER'S MAIDEN NAME

Carrie Bender

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no no.

16. SOCIAL SECURITY NO.

218-18-7096

17. INFORMANT

ADDRESS

Mrs. Margaret Parr. 815 McKim

18. 157X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Generalized Carcinoma

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

March 1950

Metastatic carcinoma of stomach

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 5-22, 1950 to 7-12, 1950, that I last saw the deceased alive on 7-12, 1950, and that death occurred at 5:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Leonard L. Vert

M. D.

23B. ADDRESS

Sinai Hospital

23C. DATE SIGNED

7/12/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/15/50

24C. NAME OF CEMETERY OR CREMATORY

Cedar Hill

24D. LOCATION (City, town, or county)

Annapolis Rd

(State)

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

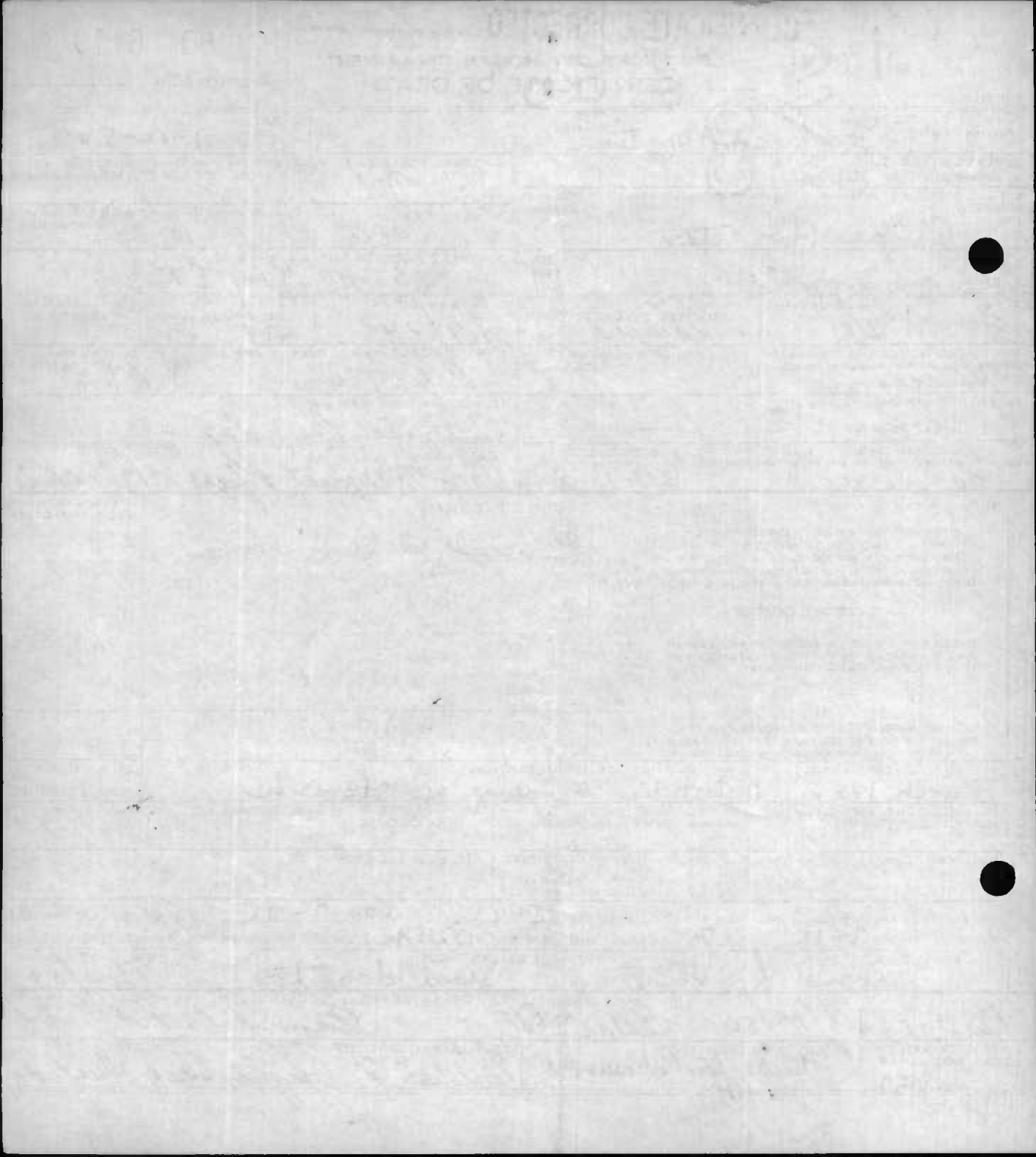
ADDRESS

Medred T. Bligh 6009 Bayford

JUL 12 1950

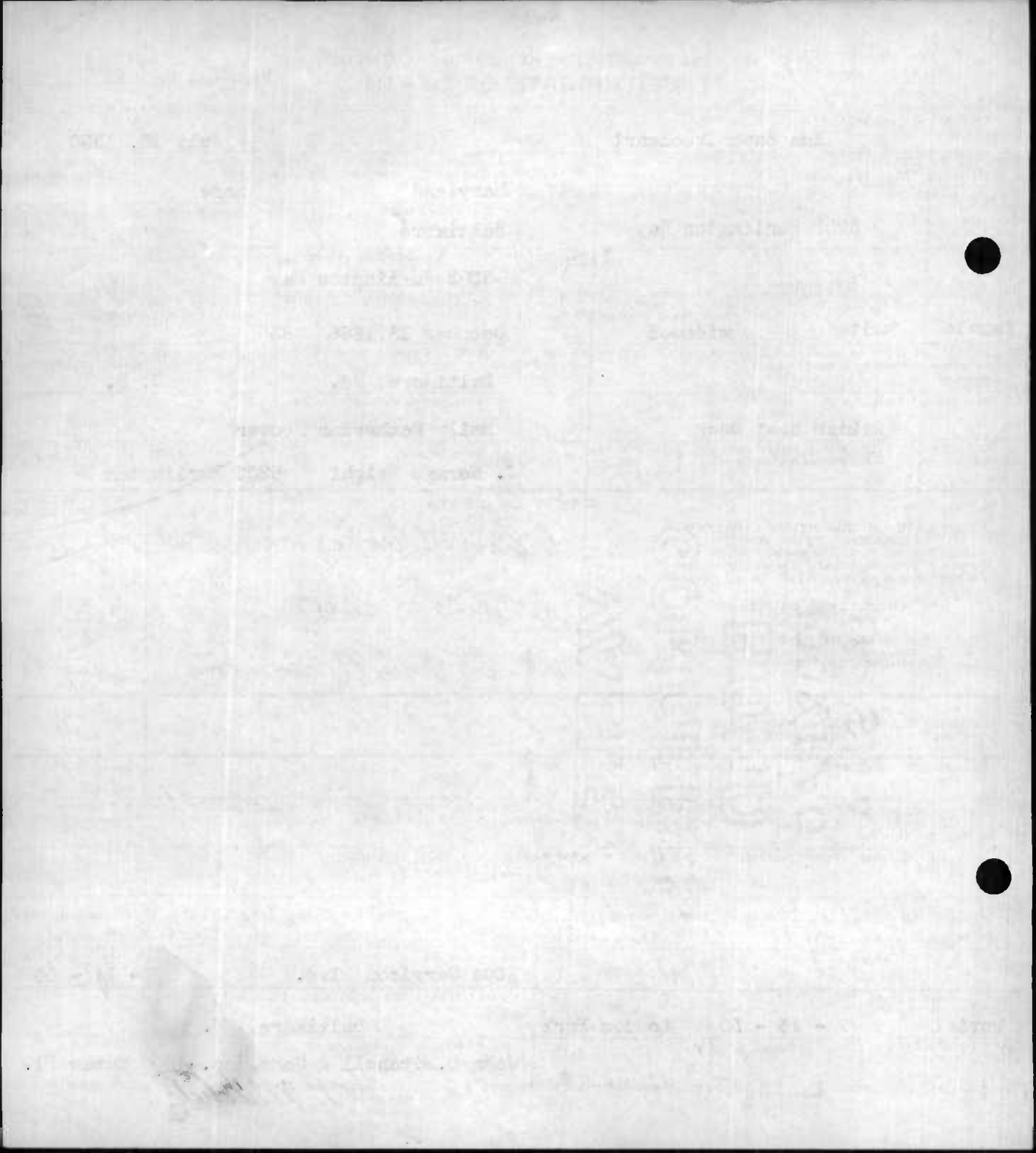
4613

MEDICAL CERTIFICATION



T-663  
50 6120BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6120  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <b>Ida Buck Trueheart</b>	
2. DATE OF DEATH <b>July 10, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>none</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>5202 Purlington Way</b>	
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>5202 Purlington Way</b>	
c. Length of stay in Baltimore <b>life</b> Yrs. Mos. Days	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>October 13, 1866</b>
9. AGE (in years last birthday) <b>83</b>	10. Under 1 Year Months Days
11. Under 24 Hours Hours Min.	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	10B. KIND OF BUSINESS OR INDUSTRY
13. FATHER'S NAME <b>Hezekiah Best Buck</b>	
14. MOTHER'S MAIDEN NAME <b>Emily Catherine Hoover</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>	16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS <b>J. Norman Wright 5202 Purlington Way</b>	
18. <b>42211</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
19A. DATE OF OPERATION <b>0</b>	
19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME (Month) (Day) (Year) (Hour) INJURY
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Jan 1 - 1948</b> , to <b>July 10, 1950</b> , that I last saw the deceased alive on <b>July 10, 1950</b> , and that death occurred at <b>10 P. m.</b> , from the causes and on the date stated above.	
23A. SIGNATURE <b>Howard J. Warner</b> M. D.	23B. ADDRESS <b>2604 Garrison Blvd.</b>
23C. DATE SIGNED <b>7 - 11 - 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>7 - 13 - 50</b>
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>UL 1-2 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>
25. FUNERAL DIRECTOR ADDRESS <b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Pl.</b>	
<b>Wm. H. Mitchell</b>	
<b>Dr. Howard J. Warner</b>	
<b>93D</b>	



P-620  
30 6121

50 6121

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>HARRY LIN WOOD PRICE</b>			2. DATE OF DEATH <b>July 11, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>2605 Royal Oak Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - 7-28-02</b>		
C. Length of stay in Baltimore <b>54</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2605 Royal Oak Avenue</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March 6, 1873</b>	9. AGE (In years, last birthday) <b>77</b>	II Under 1 Year Months Days II Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Mordecai Price</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME <b>Catherine Turner</b>	
17. INFORMANT <b>Mrs. Mabel Price</b>		ADDRESS <b>2605 Royal Oak Ave - 7-</b>			

MEDICAL CERTIFICATION

18. <b>443 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardio-vascular disease</b>			CAUSE OF DEATH (A) <b>Hypertensive cardio-vascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic cardiovascular disease</b>			(B) <b>Arteriosclerotic cardiovascular disease</b>			<b>10 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Cerebral Hemorrhage</b>			(C) <b>Cerebral Hemorrhage</b>			<b>1 year</b>		
19A. DATE OF OPERATION <b>None</b>		19B. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>None</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____				
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <b>July 11, 1949</b> , to <b>July 11, 1950</b> , that I last saw the deceased alive on <b>July 10, 1950</b> , and that death occurred at <b>4 A. M.</b> , from the causes and on the date stated above.								
23A. SIGNATURE <b>William T. Trubard</b>			23B. ADDRESS <b>3400 Woodbine Ave. Balt, Md</b>			23C. DATE SIGNED <b>7/11/50</b>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7 - 13 - 50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>		24D. LOCATION (City, town, or county) (State) <b>Centerville, Maryland</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>1-2-1950</b>		REGISTRAR'S SIGNATURE <b>William T. Trubard</b>		25. FUNERAL DIRECTOR ADDRESS <b>John O. Mitchell &amp; Sons, Inc. - 1900 Eutaw Place</b> <b>Maxton B. Mitchell</b>				

93D

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

RECEIVED

U.S. DEPARTMENT OF JUSTICE

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U.S. DEPARTMENT OF JUSTICE

RECEIVED



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6122

BIRTH NO. 50-13154

1. NAME OF DECEASED  
(Type or Print)

Katherine LaRue Downs

2. DATE  
OF  
DEATH

June 29, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

West Balto General Hosp

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

Md

B. COUNTY

C. CITY OR TOWN

Balto 11

(If outside corporate limits, write RURAL and give township)

13-05

D. STREET ADDRESS (If rural, give location)

2959 Keswick Rd

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

June 28, 1950

9. AGE (In years;  
last birthday)11 Under 1 Year  
Months: Days  
14 910A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Clarence Elroy Downs Jr.

14. MOTHER'S MAIDEN NAME

Katherine LaRue Grothe

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mother

ADDRESS

Same

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/28, 1950, to 6/29, 1950, that I last saw the  
deceased alive on 6/29, 1950, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

159

CERTIFICATE OF DEATH

1901

451

50 6123

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6123

Registered No.

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Blumberg</b>		2. DATE OF DEATH <b>July 8, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-38</b>	
C. Length of stay in Baltimore <b>2 days</b>		D. STREET ADDRESS (If rural, give location) <b>2007 Lydonlea Rd. # 14</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>July 6, 1950</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>2</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Sinai Hospital</b>	
13. FATHER'S NAME <b>Stanley Edward Blumberg</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs Norma Blumberg, 2007 Lydonlea Rd. # 14</b>		ADDRESS	

18. <b>760.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Bronchopneumonia</b> -DUE TO- (B) <b>Brain injury (not proven)</b> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
---	--	---

19A. DATE OF OPERATION <b>2</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>6 July</b> , 1950, to <b>8 July</b> , 1950, that I last saw the deceased alive on <b>8 July</b> , 1950, and that death occurred at <b>5:00 P.m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>John A. Adair</b>	23B. ADDRESS <b>1406 Eastview Place</b>	23C. DATE SIGNED <b>7/11/50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>JUL 12 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>JOHN HOPKINS MEDICAL SCHOOL</b>	24D. LOCATION (City, town, or county) (State) <b>JUL 11 1950</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 12 1950</b>	REGISTRAR'S SIGNATURE <b>Commissioner of Health</b>	ADDRESS	

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Date of birth

4. Date of death

5. Cause of death

6. Place of death

7. Signature of Registrar  
8. Signature of Medical Officer  
9. Signature of Coroner

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6124**

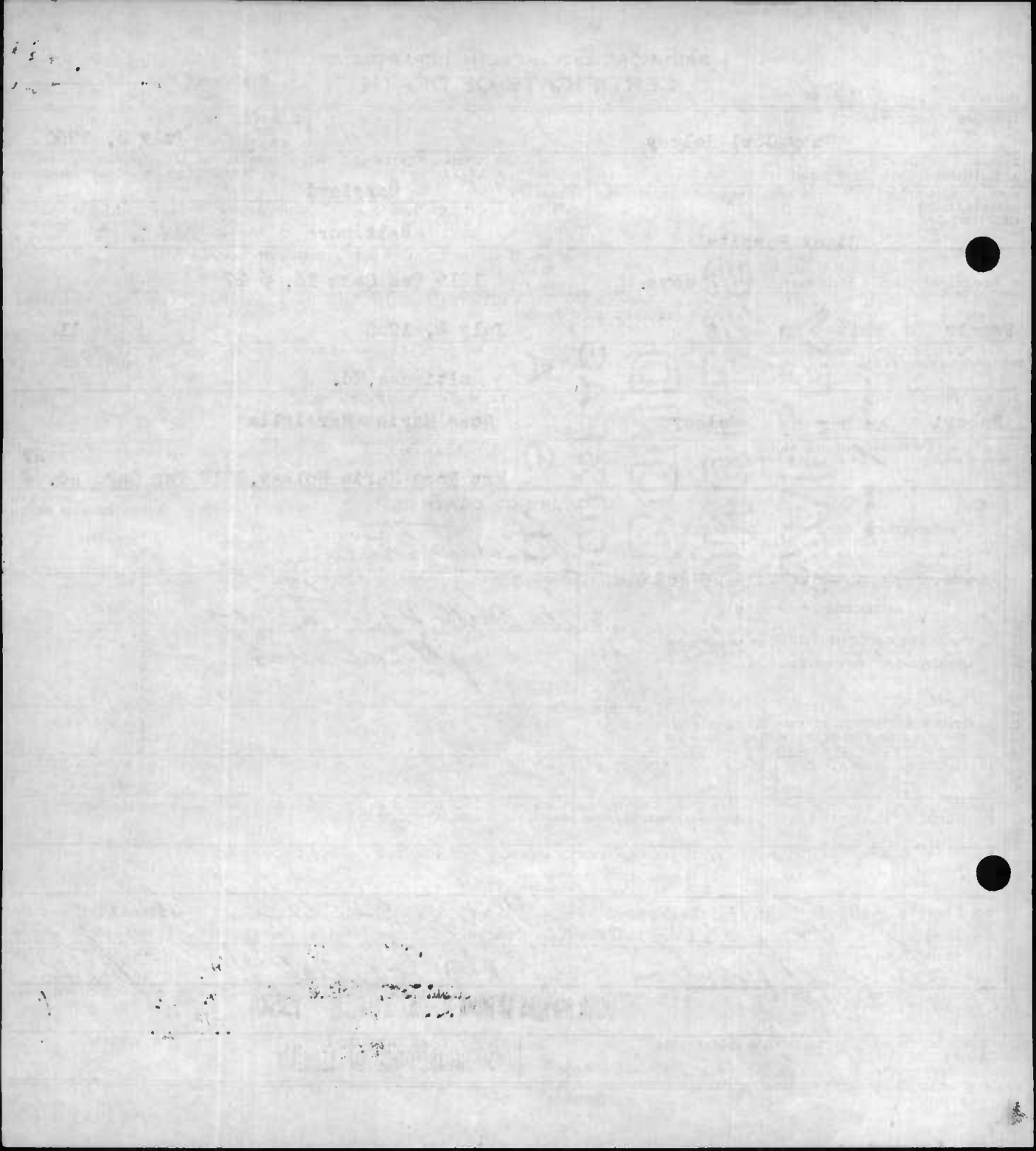
BIRTH NO. **50-13286**

1. NAME OF DECEASED (Type or Print) <b>Baby Girl Holsey</b>		2. DATE OF DEATH <b>July 3, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sirai Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>2 days.</b>		D. STREET ADDRESS (If rural, give location) <b>1219 Ten Oaks Rd. # 27</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>July 2, 1950</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>2</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>Robert Arthur Holsey</b>		12. CITIZEN OF WHAT COUNTRY? <b>11</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT ADDRESS <b>Mrs Rose Marie Holsey, 1219 Ten Oaks Rd. # 27</b>	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <b>11</b>	

18. <b>761.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> DUE TO <b>Antecedent causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Placental</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <b>Pneumonia</b> <b>Placental</b>
INTERVAL BETWEEN ONSET AND DEATH	

19A. DATE OF OPERATION <b>7/2</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/2</b> 1950 to <b>7/3</b> 1950, that I last saw the deceased alive on <b>7/2</b> 1950 and that death occurred at <b>7/3</b> 1950, from the causes and on the date stated above.					
23A. SIGNATURE <b>Samuel Butler</b>		23B. ADDRESS <b>803 Cathedral St</b>		23C. DATE SIGNED <b>7/5/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>JOHN HOPKINS MEDICAL SCHOOL</b>	
24D. LOCATION (City, town, or county)		24E. DATE <b>JUL 6 1950</b>		24F. STATE	

DATE RECEIVED BY LOCAL REGISTRAR <b>11 12 1950</b>		REGISTRAR'S SIGNATURE <b>Walter Williams</b>		25. FUNERAL DIRECTOR <b>Commissioner of Health</b>	
ADDRESS		ADDRESS		ADDRESS	





65 50 6125

541321

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6125  
Registered No.

BIRTH NO. 50-12783

1. NAME OF DECEASED  
(Type or Print)

Baby Girl Matternas

2. DATE  
OF  
DEATH June 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

The Johns Hopkins Hospital

c. Length of stay in Baltimore

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

June 20, 1950

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Matternas

14. MOTHER'S MAIDEN NAME

Louise Umberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Records

18. 761.0 I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 20, 1950 to June 20, 1950 that I last saw the  
deceased alive on June 20, 1950, and that death occurred at 10:10 Pm., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Date of Registration		12. Office of Registration	

D-431

50 6126

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6126  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cassie Dalton

2. DATE  
OF  
DEATH

7/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)

Maryland

5. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

302 Jeffrey

C. CITY OR TOWN (If outside corporate limits, write FULL and give township)

Baltimore 25-04

c. Length of stay in Baltimore

8 days

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If farm, give location)

302 Jeffrey st

5. SEX

Female

6. COLOR OR RACE

W.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Nov. 1881-7

9. AGE (in years,  
last birthday)

68

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF

Lithuania

13. FATHER'S NAME

Didbarsdio

14. MOTHER'S MAIDEN NAME

—

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Tabas

ADDRESS

302 Jeffrey st

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Congestive heart failure

Approx. 3 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic H CVD

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) Chronic glomerular nephritis

?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)  
INJURY

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐22. I hereby certify that I attended the deceased from 7/7, 1950, to 7/12, 1950, that I last saw the  
deceased alive on 7/12, 1950, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

22A. SIGNATURE

Herbert J. Erickson

M. D.

22B. ADDRESS

5305 East Drive

22C. DATE SIGNED

7/12/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

removal

24B. DATE

7/12/50

24C. NAME OF CEMETERY OR CREMATORY

Shenandoah

24D. LOCATION (City, town, or county)

Cemma

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Philip Perury Sons

ADDRESS

2024

JUL 12 1950

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Orlean

Nov 44 9

200

6127

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6127

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LEIGH, WILLIAM FITCHETT

2. DATE  
OF  
DEATH

7/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

U.S. MARINE HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

VA.

C. CITY OR TOWN

DUTTON

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

26

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

3/8/09

9. AGE (In years  
last birthday)

41

If Under 1 Year  
Months: Days

4 4

If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

MERCHANT SEAMAN

10B. KIND OF BUSINESS OR  
INDUSTRY

SHIPPING, FISHING

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

SAMUEL B. LEIGH

14. MOTHER'S MAIDEN NAME

LUCY O. FITCHETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. 163X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CARCINOMA OF RT. LUNG

1 YR.

ANTECEDENT CAUSES

DUE TO

(B) UNKNOWN

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C) —

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

4/26/50

19B. MAJOR FINDINGS OF OPERATION

CARCINOMA RT. LUNG

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 July, 1950, to 12 July, 1950, that I last saw the  
deceased alive on 12 July, 1950, and that death occurred at 8:25 P.M., from the causes and on the date stated above.

23A. SIGNATURE

William J. Budington, M.D.

23B. ADDRESS

U.S. Marine Hosp. Balto 12 Md

23C. DATE SIGNED

7/12/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

REMOVAL

24B. DATE

7/13/50

24C. NAME OF CEMETERY OR CREMATORY

LOBUST GROVE

24D. LOCATION (City, town, or county) (State)

SOLES, VA.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William J. Budington, M.D.

25. FUNERAL DIRECTOR

Wm J. Tickner &amp; Sons

ADDRESS

NORTH 6th Ave

VS 150

673 55

Balto. Md.

47D

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

LEAH, William Mitchell

Name of Deceased		LEAH, William Mitchell	
Date of Death		1910	
Place of Death		New York	
Cause of Death		Died of	
Age at Death		30	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		None	
Residence at Death		New York	
Burial Place		New York	
Signature of Registrar		[Signature]	
Signature of Physician		[Signature]	
Signature of Coroner		[Signature]	
Signature of Minister		[Signature]	
Signature of Undertaker		[Signature]	
Signature of Witnesses		[Signatures]	



532  
0 6128

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6128

Registered No. \_\_\_\_\_

BIRTH NO. _____			1. NAME OF DECEASED (Type or Print) <b>Estella M. Wentz</b>			2. DATE OF DEATH <b>July 10, 1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>						
B. FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) <b>Hood Nursing Home</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Parkville</b>						
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>8216 Wilson Avenue</b>						
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>Nov. 26, 1871</b>		9. AGE (In years last birthday) <b>78</b>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Mullen</b>			14. MOTHER'S MAIDEN NAME <b>Mary J. Wallace</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Hazel Steinitz, 8216 Wilson Avenue</b>				
18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Here brace Arterio Sclerosis 1 yr</b> DUE TO <b>Generalized Arterio Sclerosis</b> DUE TO <b>Myocardial Infarction 2 days</b>			INTERVAL BETWEEN ONSET AND DEATH						
19A. DATE OF OPERATION <b>0</b>			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>May 7, 1950</b> , to <b>June 10, 1950</b> , that I last saw the deceased alive on <b>June 10, 1950</b> , and that death occurred at <b>11 P. M.</b> , from the causes and on the date stated above.									
23A. SIGNATURE <b>James H. Brown</b>			23B. ADDRESS <b>Laconia</b>			23C. DATE SIGNED <b>7-11-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/13/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul Street</b>			

MEDICAL CERTIFICATION

WILEY

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Place of Death	
Sex		Age	
Cause of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Time of Report	

325  
50 6129

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6129  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Annie M. WATKINS</b>		2. DATE OF DEATH <b>July 11, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1400 W. Lexington St.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Aged Women's &amp; Aged Men's Homes</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1400 W. Lexington Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>May 30, 1872</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>John Y. Zile</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Hoff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>L. H. Read</b>		ADDRESS <b>1400 W. Lexington Street</b>	

18. <b>260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus</b>		<b>104RS</b>
(C) <b>HYPERTENSIVE C-V-D</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

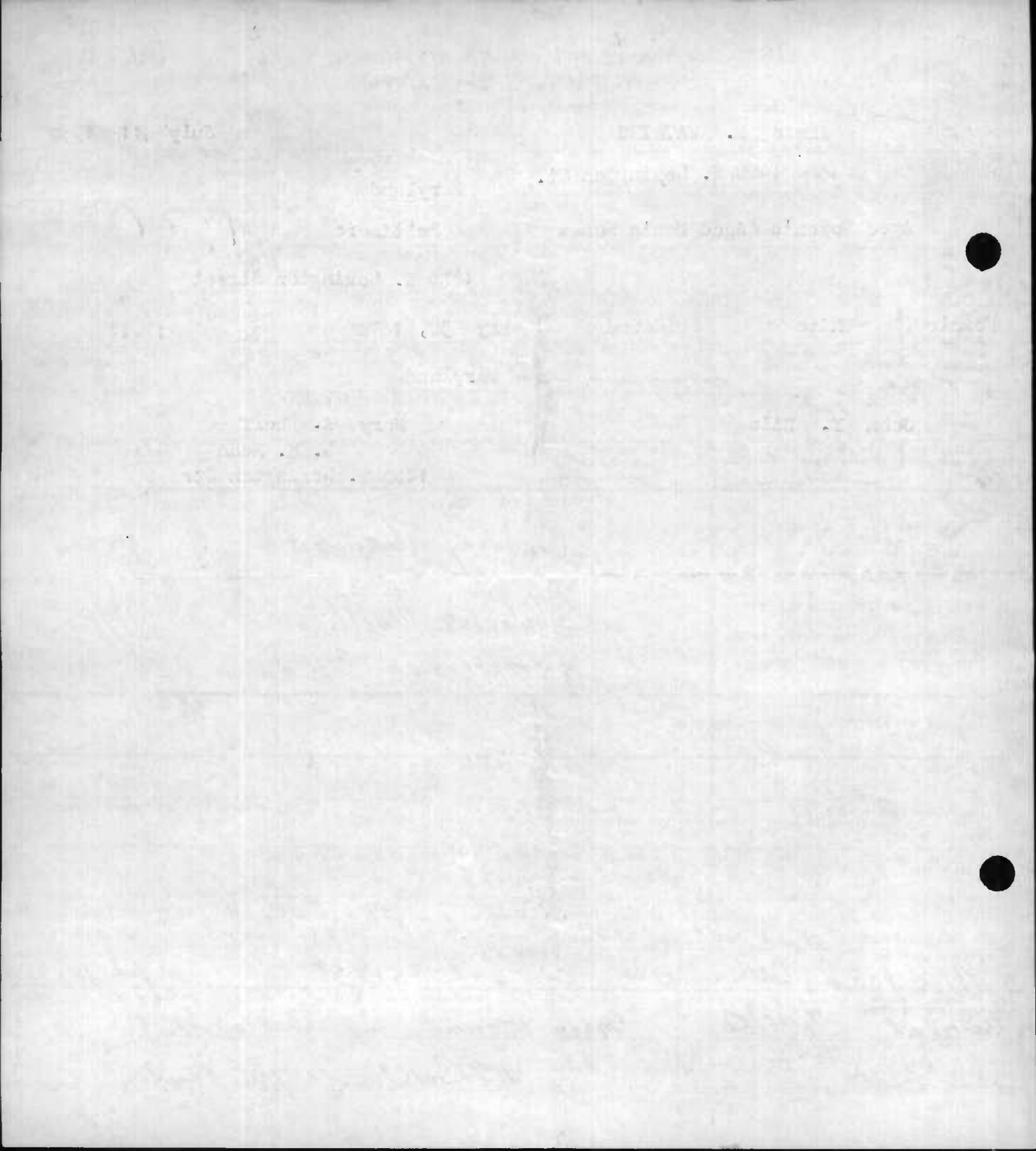
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **JAN. 1949**, to **JULY 11, 1950**, that I last saw the deceased alive on **JULY 11, 1950**, and that death occurred at **6:55 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Neeland Edward Day</b>	23B. ADDRESS <b>4-2-33rd St</b>	23C. DATE SIGNED <b>July 12, 1950</b>
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24A. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/14/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. Cook Inc.</b>	25. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul St.</b>
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516  
50 6130  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6130

1. NAME OF DECEASED (Type or Print) <b>John H. Lambright</b>		2. DATE OF DEATH <b>7-11-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1739 Carswell Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. 9-07</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1739 Carswell Street</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>8-8-88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steward</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	9. AGE (In years last birthday) <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF USA COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Lambright</b>		14. MOTHER'S MAIDEN NAME <b>Rose M. Hemley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>August Lambright-2719 Northern Pkwy.</b>		ADDRESS	

18. <b>177X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Prostate</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	CAUSE OF DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Mar.</b> , 19 <b>50</b> , to <b>July</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 11</b> , 19 <b>50</b> , and that death occurred at <b>8:10 A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Lois M. Zeinman</b> M. D.		23B. ADDRESS <b>2058 Harford Rd</b>		23C. DATE SIGNED <b>July 13, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-14-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Jerusalem</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler, 403 S. Wolfe Street</b>	

7646A 6131

51B

2858

1-1-7

John E. Smith

Mr.

John E. Smith

1-1-7

John E. Smith

John E. Smith

John E. Smith

John E. Smith

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John E. Smith



# CERTIFICATE CORRECTED 7-20-50

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 6131

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth Mary Gummer

2. DATE OF DEATH July 11, 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
St. Joseph's

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Married

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Md.  
B. COUNTY 8-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
1211 N. Curley St.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Wife.

10B. KIND OF BUSINESS OR INDUSTRY

8. DATE OF BIRTH 1898  
May 8, 1899

9. AGE (In years last birthday) 52-51  
If Under 1 Year: Months: Days  
If Under 24 Hours: Hours: Min.

11. BIRTHPLACE (State or foreign country)  
Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
Joseph Trabert

14. MOTHER'S MAIDEN NAME  
Barbara ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS  
John Gummer - Above

18. 443X

### CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease

DUE TO

### II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 10, 1950, to July 11, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE  
Madlena Sawinski

M. D.

23B. ADDRESS  
1400 N. Caroline St.

23C. DATE SIGNED  
July 11, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE  
7-15-50

24C. NAME OF CEMETERY OR CREMATORY  
Holy Redeemer

24D. LOCATION (City, town, or county) (State)  
Baltimore, MD

DATE RECEIVED BY LOCAL REGISTRAR  
JUL 13 1950

REGISTRAR'S SIGNATURE  
Thurston Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Lilly & Zeiler, 403 S. Wolfe Street

5/8/1899 - 51

Jos. Grabert

Barbours -

John Sumner - above

536  
6132

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6132

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>SARA S. CANTOR</b>			2. DATE OF DEATH <b>7/12/50</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>DOCTOR'S HSPTL N CHARLES ST</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY _____		
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>DOCTOR'S HSPTL N CHARLES ST Balt Md</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 13-01</b>		
c. Length of stay in Baltimore <b>35 Yrs.</b>			d. STREET ADDRESS (If rural, give location) <b>801 Lake Drive</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 15, 1897</b>		9. AGE (In years, last birthday) <b>52</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Felix Slusky</b>			14. MOTHER'S MAIDEN NAME <b>Sophia ??</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT ADDRESS <b>Mr. Isidor Cantor-801 Lake Drive</b>		

18. <b>151X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ADENO-CARCINOMA OF STOMACH</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>GENEALIZED METASTASIS</b> DUE TO <b>ASCITES</b>	INTERVAL BETWEEN ONSET AND DEATH <b>20 MONTHS</b> <b>6 MONTHS</b> <b>2 weeks</b>
--	---

19a. DATE OF OPERATION <b>MARCH 1949</b>	19b. MAJOR FINDINGS OF OPERATION <b>ADENO-CARCINOMA OF STOMACH</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21d. TIME (Month) (Day) (Year) (Hour) INJURY _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **MARCH 1949** to **July 12, 1950** that I last saw the deceased alive on **7/11/50** and that death occurred at **11:55A m.**, from the causes and on the date stated above.

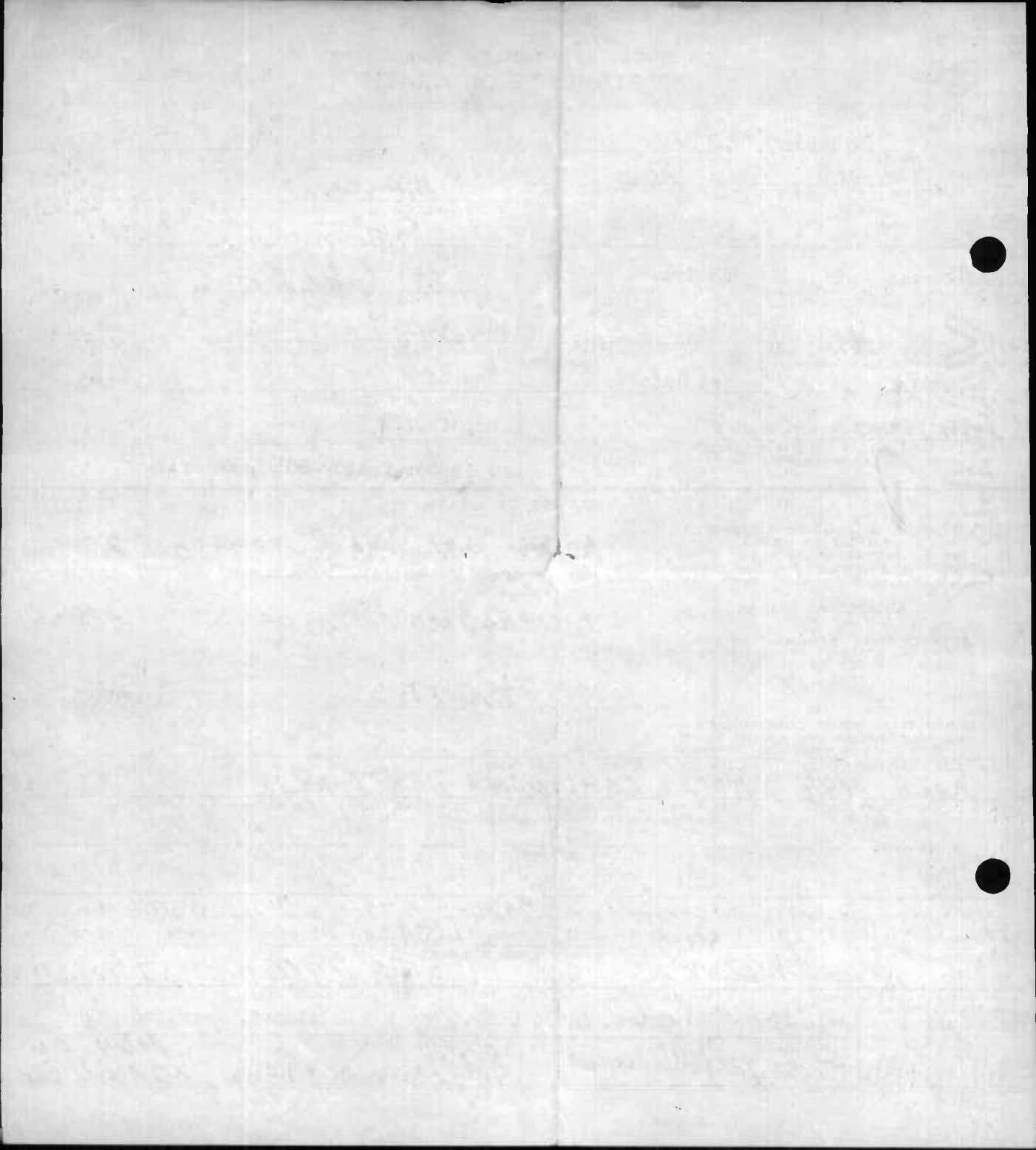
23a. SIGNATURE <b>Blay A Weinstein</b>	23b. ADDRESS <b>4603 PK Htrane</b>	23c. DATE SIGNED <b>7/12/50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7-13-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Chizuk Amuno Cong.</b>
24d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, MD</b>	25 FUNERAL DIRECTOR <b>Sol. Levinson &amp; Bros</b>
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1124-26

46B

MEDICAL CERTIFICATION



430  
0 6133BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6133  
Registered No.

1. NAME OF DECEASED (Type or Print)		WILLIAM ELLIOTT		2. DATE OF DEATH July 10, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION 639 Dolphin Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 639 Dolphin Street			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 6, 1880	9. AGE (In years last birthday) 70	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) News Man		10B. KIND OF BUSINESS OR INDUSTRY News Paper Industry		11. BIRTHPLACE (State or foreign country) Richmond, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Joseph Elliott.		14. MOTHER'S MAIDEN NAME Cornelia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mary Booker, 639 Dolphin St.	
18. 443X 177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Carcinoma of prostate		(A) DUE TO		(B) DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO		(D) DUE TO	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE R.S. Fisher		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED 7-11-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-13-1950		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Balto.		24E. STATE Md.		24F. DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1950	
24G. REGISTRAR'S SIGNATURE Huntington Williams, M.D.		24H. FUNERAL DIRECTOR Mrs. Katie R. Williams		24I. ADDRESS 322 N. Schradewort	

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6134

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

S. Felix Hein, Sr.

2. DATE  
OF  
DEATH

July 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1225 W. Lombard St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Baker

10B. KIND OF BUSINESS OR INDUSTRY

Retired

13. FATHER'S NAME

John V. Hein

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

219-10-3559A

17. INFORMANT

ADDRESS

John V. Hein 1225 W. Lombard St.

**CAUSE OF DEATH**

18. 420.1

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A) .....  
DUE TO .....  
(B) .....  
DUE TO .....  
(C) .....

Coronary sclerosis  
Generalized sclerosis  
Arterio-

INTERVAL BETWEEN  
ONSET AND DEATH

6 Hrs.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 6/30/50 to 7/10/50, that I last saw the deceased alive on 7/1/50, and that death occurred at 5:23 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 13, 1950

Holy Redeemer

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 13 1950

Wm. H. Williams, M.D.

Frederick A. Cole 1913 W. Balto. St.

1000

*[Faint handwritten notes at the bottom of the page]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6135

BIRTH NO. <u>6135</u>		1. NAME OF DECEASED (Type or Print) <u>PRISCILLA ROGERS</u>		2. DATE OF DEATH <u>7-9-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>01</u>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <u>632 A 21st Street W.</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-31-1904</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE (In years last birthday) <u>46</u>		11. BIRTHPLACE (State or foreign country) <u>King George county Va.</u>
13. FATHER'S NAME <u>Rogers</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. MOTHER'S MARDEN NAME <u>Carrie Rogers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Esula Thomas</u> ADDRESS <u>715 Florida Ave NE</u>	
18. <u>456 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH  (A) <u>Disseminated Lupus Erythematosus</u> DUE TO  (B) <u>(Erythematosus)</u> DUE TO  (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>None</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>None</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>50</u> to <u>July 9</u> , 19 <u>50</u> that I last saw the deceased alive on <u>July 9</u> , 19 <u>50</u> and that death occurred at <u>6 P.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Eleanor W. Demarest</u> M.D.		23B. ADDRESS <u>University Hosp.</u>		23C. DATE SIGNED <u>7-10-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7-13-1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Auburn cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore city Maryland</u>		25. FUNERAL DIRECTOR <u>Joseph A. Lindy</u>		ADDRESS <u>661 W. Basse Street</u>	

MEDICAL CERTIFICATION

STATE OF NEW YORK  
CERTIFICATE OF DEATH

JAN 11 1944

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

# CERTIFICATE CORRECTED 7-18-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 6136

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MABEL L. WISNER

2. DATE  
OF  
DEATH

July 11, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2227 Reisterstown Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

d. STREET ADDRESS (If rural, give location)

2227 Reisterstown Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

March 18, 1898

9. AGE (in years last birthday)

64 52

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Lewis H. Wisner

14. MOTHER'S MAIDEN NAME

Margaret Hart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mrs. Edith V. Wentworth 2227 Reisters-

18.

### CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis.

DUE TO

### ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary emphysema

DUE TO

(C) Bronchial asthma & chronic bronchitis.

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) INJURY

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 7-3 1950, to 7-11 1950, that I last saw the deceased alive on 7-7 1950, and that death occurred at 11 53p. m., from the causes and on the date stated above.

23a. SIGNATURE

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24b. DATE

7/14/50

24c. NAME OF CEMETERY OR CREMATORY

Westminster Cem.

24d. LOCATION (City, town, or county)

Westminster, Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 13 1950

Wilmington Williams, Md.

Wm. J. Vickers & Sons Balto Md.

100-10000

100-10000

100-10000

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160  
50 6137BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6137  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ELEANOR LOIS COVER

2. DATE  
OF  
DEATH

7-10-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

University Hosp.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
single10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Record Clerk

10B. KIND OF BUSINESS OR  
INDUSTRY  
Westinghouse Elec.

13. FATHER'S NAME

Harry D. Cover

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Md.

B. COUNTY

A. A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Lansdowne

D. STREET ADDRESS (If rural, give location)

2803 Hammonds Ferry Rd.

8. DATE OF BIRTH

July 23, 1923

9. AGE (In years  
last birthday)

26

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Rose T. Cover

17. INFORMANT

ADDRESS

Mrs. Rosa T. Cover 2803 Hammonds Ferry Rd.

18. 593 X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Uremia Hypertension

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Nephritis Hypertension

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/24, 1950, to 7-10, 1950, that I last saw the  
deceased alive on 7-10, 1950, and that death occurred at 2:50 Pm., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

7-10-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

7/14/50

Cathedral Cem.

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 13 1950

Tunington Williams, M.D.

Wm. F. Dickens &amp; Sons Balto

CERTIFICATE OF DEATH

NEW YORK

DECEASED

NAME

AGE

SEX

RACE

DATE OF DEATH

19

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6138

623  
6138  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>NATHANIEL IRVIN GRESSITT</b>		2. DATE OF DEATH <b>7/11/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 12-06</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2700 N. CHARLES</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 3, 1877</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ATTORNEY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LAW ATTORNEY</b>	9. AGE (In years last birthday) <b>73</b>
13. FATHER'S NAME <b>JOHN B. GRESSITT</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or <u>unknown</u> ) <b>none</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>none</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA Ellen Muse</b>	
17. INFORMANT <b>Mrs.</b>		ADDRESS	

18. <b>191X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.	CAUSE OF DEATH (A) <b>PNEUMONIA + PLEURAL EFFUSION</b> DUE TO (B) <b>CARCINOMA, METASTATIC</b> DUE TO (C) <b>CARCINOMA - PERIANAL REGION</b> <b>ASTHMA</b>	INTERVAL BETWEEN ONSET AND DEATH <b>NOT KNOWN</b>          <b>3 yrs</b>
--	--	--

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>JULY 8, 1950</b> , to <b>JULY 11, 1950</b> , that I last saw the deceased alive on <b>JULY 8, 1950</b> , and that death occurred at <b>9:18 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Francis N. Wan</b>		23B. ADDRESS M. D. <b>Union Memorial Hosp.</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/14/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Lickner &amp; Sons</b>		ADDRESS <b>Balto Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Lickner</b>		25. FUNERAL DIRECTOR <b>Wm. J. Lickner &amp; Sons</b>	

VS 150  
05580 39 53

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1917

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

520  
50 6139BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6139  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Edna Thomas</b>		2. DATE OF DEATH <b>JUL 11 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		c. CITY OR TOWN, (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>1021 N. Stricker St</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W.</b>	8. DATE OF BIRTH <b>4-4-92</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>58</b>
10. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY	
12. FATHER'S NAME		13. MOTHER'S MAIDEN NAME	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		15. SOCIAL SECURITY NO.	
16. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>		17. ADDRESS	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>LEUKOCYTOSIS</b> <b>Thrombosis of R. brachiocephalic artery with left embolgia</b> <b>Hypertensive and arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3d</b> <b>&gt; 6 YRS.</b>	
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		20b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
20e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		20f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6-18-</b> , 19 <b>50</b> , to <b>7-11-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-11-</b> , 19 <b>50</b> , and that death occurred at <b>11:25 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Thomas E. Van Metre Jr.</b>		23b. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	
23c. DATE SIGNED <b>12 July 50</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>7-15-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>	
24d. LOCATION (City, town, or county) (State) <b>Balt. Co. Md</b>		25. FUNERAL DIRECTOR <b>Matthias A. Hurdley</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>William Williams</b>	

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24/12

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 6140  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>THOMAS CRISTE</b>		2. DATE OF DEATH <b>July 12, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>V-35</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>West Baltimore General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Harrisburg</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2773 Rumson Avenue</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 27, 1914</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchandiser</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Philadelphia Dairy</b>	9. AGE (In years last birthday) <b>36</b>
11. BIRTHPLACE (State or foreign country) <b>Cresson, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Sherman Criste</b>		14. MOTHER'S MAIDEN NAME <b>Mary Karney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Funeral Director Conrad, Cresent, Penna.</b>		ADDRESS	

18. <b>CAUSE OF DEATH</b>	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  (A) <b>Crushing injury of chest</b> DUE TO _____  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ DUE TO _____ (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Rolling Road &amp; Johnny Cake Road, Balto. Co.</b>
21D. TIME (Month) (Day) (Year) (Hour) <b>July 12, 1950 11:40 Am.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Auto &amp; trailer-truck collision. Passenger thrown from auto-- run over by trailer-truck.</b>
22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <b>RS Fisher</b>	23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>July 12, 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24B. DATE <b>7/13/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Summit, Pennsylvania</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>	
		ADDRESS <b>1217 St. Paul Street</b>	

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MADDEX

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6141

Registered No. \_\_\_\_\_

BIRTH NO. 50-14073

1. NAME OF DECEASED  
(Type or Print) *Madden, Baby Boy*

2. DATE OF DEATH *July 12, 50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *Baltimore*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE *MD* B. COUNTY *Baltimore*

B. FULL NAME OF HOSPITAL OR INSTITUTION *St. Mary's Hospital*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) *Baltimore, MD*

D. STREET ADDRESS (If rural, give location) *2926 Yorkway*

c. Length of stay in Baltimore *Life*

5. SEX *Male*

6. COLOR OF RACE *White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Infant*

8. DATE OF BIRTH *July 16, 1950*

9. AGE (In years last birthday) *1 day*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even retired) *Infant*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *Baltimore, MD*

12. CITIZEN OF WHAT COUNTRY? *U.S.*

13. FATHER'S NAME *Michael Joseph Madden*

14. MOTHER'S MAIDEN NAME *Bethie Elaine*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) *No*

16. SOCIAL SECURITY NO. *7630*

17. INFORMANT *Mother* ADDRESS *Same*

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  
*Aspiratic Pneumonia*

19. ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
*Difficult Labor*

20. AUTOPSY? YES ☒ NO ☐

19A. DATE OF OPERATION *7/1/50*

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 11, 1950* to *July 12, 1950*, that I last saw the deceased alive on *July 12, 1950*, and that death occurred at *m.*, from the causes and on the date stated above.

23A. SIGNATURE *Man E. Matthews*

23B. ADDRESS *St. Mary's Hospital*

23C. DATE SIGNED *July 12, 50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *7/1/50*

24C. NAME OF CEMETERY OR CREMATORY *Howe Cemetery*

24D. LOCATION (City, town, or county) (State) *Baltimore City*

DATE RECEIVED BY LOCAL REGISTRAR *JUL 13 1950*

REGISTRAR'S SIGNATURE *Wm. H. Williams, M.D.*

25. FUNERAL DIRECTOR *George J. Ruth, Inc.* ADDRESS *1735 Harford Ave*

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U.S. DEPARTMENT OF COMMERCE  
BUREAU OF MARITIME SERVICE

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50 6142BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6142  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>FRANK ALFORD</b>		2. DATE OF DEATH <b>July 9, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>US Marine Hospital</b> <b>Wyman Pk. Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>8-07</b>	
C. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1714 E. Chase Street</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>separated</b>	8. DATE OF BIRTH <b>5/11/20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>30</b>
11. BIRTHPLACE (State or foreign country) <b>SC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joe Alford</b>		14. MOTHER'S MAIDEN NAME <b>Josephine James</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b>		16. SOCIAL SECURITY NO. <b>249-26-0672</b>	
17. INFORMANT <b>Records- US Marine Hospital, Balto, Md.</b>		ADDRESS	
18. <b>422.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic myocarditis with cardiac hypertrophy and dilatation, right and left and cardiac failure</b> DUE TO (A) <b>Chronic myocarditis with cardiac hypertrophy and dilatation, right and left and cardiac failure</b> DUE TO (B) <b></b> DUE TO (C) <b></b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b></b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>
19A. DATE OF OPERATION <b>2</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 20</b> , 19 <b>50</b> , to <b>July 9</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 9</b> , 19 <b>50</b> , and that death occurred at <b>3:30A</b> m., from the causes and on the date stated above.			
23A. SIGNATURE <b>John L. Wilson, Medical Director</b> M. D.		23B. ADDRESS <b>US Marine Hospital, Balto, Md.</b>	
23C. DATE SIGNED <b>7/10/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>July 14/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Int Calvary Cem</b>	24D. LOCATION (City, town, or county) (State) <b>9.9. County Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>1129 N. Caroline St</b>		ADDRESS <b>Mrs Robert A. Elliott &amp; Daughter</b>	

STATE OF NEW YORK  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Physician	
10. Signature of Registrar		11. Signature of Coroner		12. Signature of Medical Examiner	
13. Signature of Burial Officer		14. Signature of Undertaker		15. Signature of Funeral Home	
16. Signature of Cemetery		17. Signature of Burial		18. Signature of Interment	
19. Signature of Burial		20. Signature of Interment		21. Signature of Burial	
22. Signature of Interment		23. Signature of Burial		24. Signature of Interment	
25. Signature of Burial		26. Signature of Interment		27. Signature of Burial	
28. Signature of Interment		29. Signature of Burial		30. Signature of Interment	
31. Signature of Burial		32. Signature of Interment		33. Signature of Burial	
34. Signature of Interment		35. Signature of Burial		36. Signature of Interment	
37. Signature of Burial		38. Signature of Interment		39. Signature of Burial	
40. Signature of Interment		41. Signature of Burial		42. Signature of Interment	
43. Signature of Burial		44. Signature of Interment		45. Signature of Burial	
46. Signature of Interment		47. Signature of Burial		48. Signature of Interment	
49. Signature of Burial		50. Signature of Interment		51. Signature of Burial	
52. Signature of Interment		53. Signature of Burial		54. Signature of Interment	
55. Signature of Burial		56. Signature of Interment		57. Signature of Burial	
58. Signature of Interment		59. Signature of Burial		60. Signature of Interment	
61. Signature of Burial		62. Signature of Interment		63. Signature of Burial	
64. Signature of Interment		65. Signature of Burial		66. Signature of Interment	
67. Signature of Burial		68. Signature of Interment		69. Signature of Burial	
70. Signature of Interment		71. Signature of Burial		72. Signature of Interment	
73. Signature of Burial		74. Signature of Interment		75. Signature of Burial	
76. Signature of Interment		77. Signature of Burial		78. Signature of Interment	
79. Signature of Burial		80. Signature of Interment		81. Signature of Burial	
82. Signature of Interment		83. Signature of Burial		84. Signature of Interment	
85. Signature of Burial		86. Signature of Interment		87. Signature of Burial	
88. Signature of Interment		89. Signature of Burial		90. Signature of Interment	
91. Signature of Burial		92. Signature of Interment		93. Signature of Burial	
94. Signature of Interment		95. Signature of Burial		96. Signature of Interment	
97. Signature of Burial		98. Signature of Interment		99. Signature of Burial	
100. Signature of Interment		101. Signature of Burial		102. Signature of Interment	



L-220

CERTIFICATE CORRECTED 7-17-50

50 6143

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 50 6143

1. NAME OF DECEASED  
(Type or Print)

Mrs. Florence Bertha Lucas

2. DATE  
OF  
DEATH

July 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

St. Joseph's Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

1882

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

August

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Evelyn Hladky 1910 Perlman Place

18. 576 X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Generalized peritonitis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Ruptured Viscus (probably)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/10/1950 to 7/12/1950 that I last saw the  
deceased alive on 7/12/50, 19, and that death occurred at 6:30 A.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

E. Paul Coffey Jr.

M. O.

1400 N. Caroline Street

7/12/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

July 14, 1950

Balto. Cem.

E. North Ave. E. St.

DATE RECEIVED BY REGISTRAR'S SIGNATURE  
LOCAL REGISTRAR

25. FUNERAL DIRECTOR

ADDRESS

JUL 13 1950

Huntington Williams, M.D.

Leslie Book 1703 N. Patterson Park Ave

129

MEDICAL CERTIFICATION

NOT A MEDICAL EXAMINER'S CASE

*R. J. Fisher*

U.S.

CHIEF OR ASST. MEDICAL EXAMINER

NOT A MEDICAL EXAMINER'S CASE

U.S.  
CHIEF OR ASST. MEDICAL EXAMINER

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6144**

**242**  
**6144**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>McELGUNN, JOHN P.</b>			2. DATE OF DEATH <b>7-12-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 16-08</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>900 N. Augusta Ave</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>3/17/1904</b>	9. AGE (In years last birthday) <b>46</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during any of working life, even if retired) <b>Deputy Register</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Court House</b>	11. BIRTH PLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Dennis McElgunn</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Hurley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or onkooow) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Katherine K. McElgunn</b> ADDRESS <b>900 N. Augusta Ave</b>		

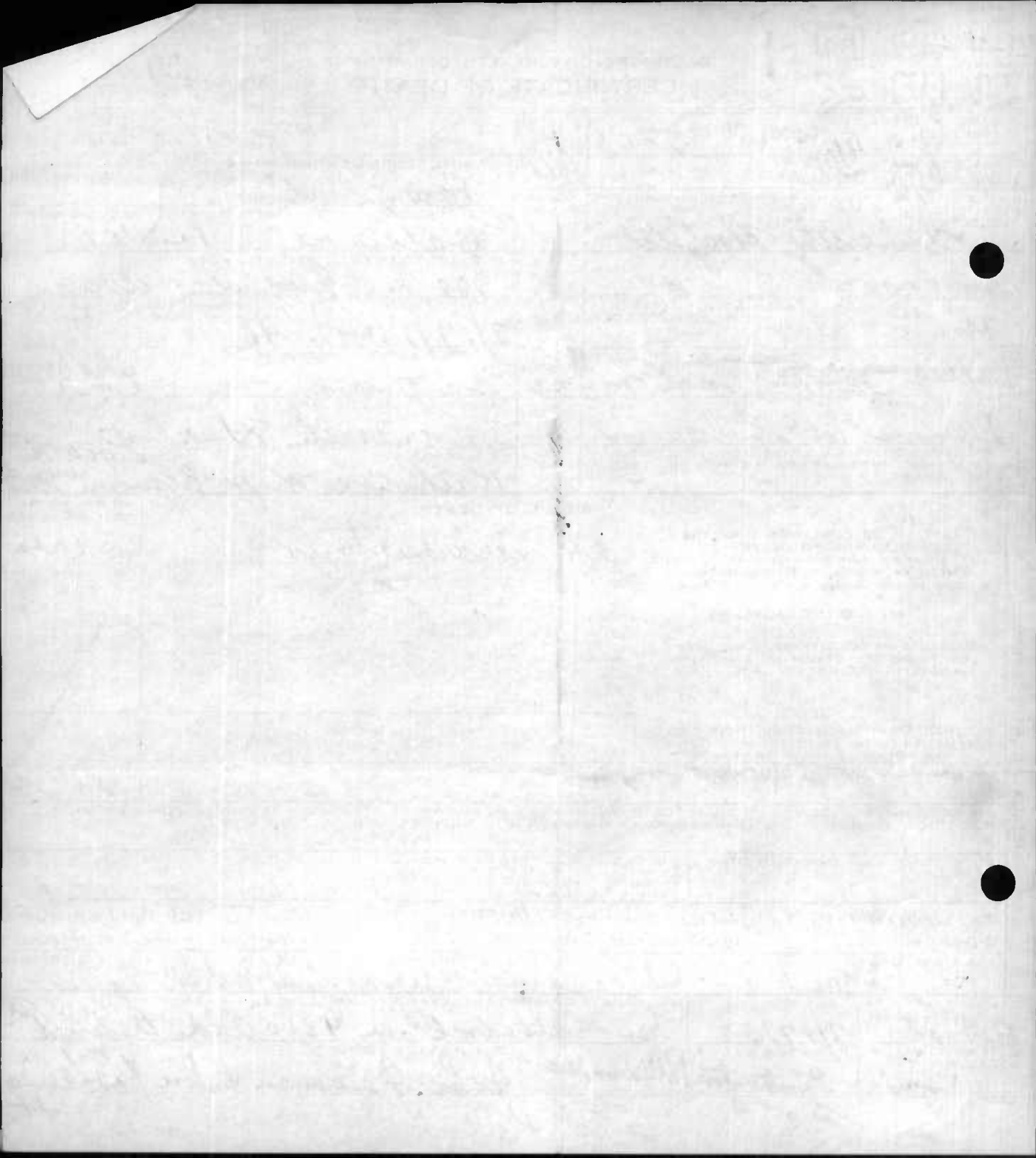
18. <b>289.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hemicromatosis</b>	CAUSE OF DEATH (A) <b>Hemicromatosis</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>3 + hrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <input type="checkbox"/>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **7/11/50**, 19**50**, to **7/12**, 19**50**, that I last saw the deceased alive on **7-12**, 19**50**, and that death occurred at **9:30** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Ernest E. Cole</b> M.D.		23B. ADDRESS <b>University Hospital (Baltimore)</b>		23C. DATE SIGNED <b>7-12-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/17/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>4300 Old Frederick St. Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>John J. Loran &amp; Son</b> ADDRESS <b>2200 N. Hollins St.</b>	

MEDICAL CERTIFICATION



212  
50 6145

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6145  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Marie Anna Machovec</i>		2. DATE OF DEATH <i>July 11, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland 2531 Ashland Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 7-02</i>	
C. Length of stay in Baltimore <i>life</i>		D. STREET ADDRESS (If rural, give location) <i>2531 Ashland Avenue</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>Dec. 8, 1872</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>77</i> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Joseph Baroch</i>		14. MOTHER'S MAIDEN NAME <i>Anna Stepanek</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James J. Machovec, son, 710 N. Glover St.</i>		ADDRESS	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Occlusion</i> DUE TO <i>Chronic Myocarditis</i> DUE TO <i>3 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION <i>None</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>None</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY <i>None</i>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 6th 1950</i> , to <i>July 11th 1950</i> , that I last saw the deceased alive on <i>July 10, 1950</i> , and that death occurred at <i>12:25 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>L. J. Cordy</i>		23B. ADDRESS <i>5106 Harford Road</i>		23C. DATE SIGNED <i>7-11-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 14, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>4430 Belair Rd., Balto. Md.</i>		25. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i>		ADDRESS <i>2601-3-5 E. Madison St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 13 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams</i>			

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H-425

50 6146

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6146

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CLARA M. HEILIGENSTADT

2. DATE  
OF  
DEATH

July 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)

600 Kingston Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Baltimore

D. STREET ADDRESS (If rural, give location)

600 Kingston Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widow

8. DATE OF BIRTH

June 27, 1864

9. AGE (In years  
last birthday)

86

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles Phillips

14. MOTHER'S MAIDEN NAME

Mary Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ed. W. Maasch 600 Kingston Rd.

18. 422.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(A)

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

12 hrs

years?

11 years

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1925, 19 July 17, 1950, that I last saw the  
deceased alive on July 11, 1950, and that death occurred at 4:35 a. m. from the causes and on the date stated above.

23A. SIGNATURE

William R. Braghty

M. D.

23B. ADDRESS

10 E Biddle St

23C. DATE SIGNED

July 13/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/15/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Cem.

24D. LOCATION (City, town, &amp; county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tiekens &amp; Sons, Balto. Md.

JUL 13 1950  
VS 150

937

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420  
0 6147BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6147

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Mattie Black</i>		2. DATE OF DEATH <i>July 12 1958</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>1102 Peach St</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i> <i>23-01</i>	
c. Length of stay in Baltimore <i>26</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1102 Peach Street</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>2/4/1873</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>N. W</i>	9. AGE (In years last birthday) <i>77</i>
11. BIRTHPLACE (State or foreign country) <i>Ga</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Allen Meadows</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Rona Black 11035 Sharp St</i>
18. <i>592X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Chronic Nephritis</i> DUE TO (B) <i>Senile changes</i> DUE TO (C) _____  INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>  <i>"</i>	
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 22, 1958</i> , to <i>July 12, 1958</i> , that I last saw the deceased alive on <i>July 16, 1958</i> , and that death occurred at <i>12:00 pm.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>Shirley Gaines</i> M. O.		23B. ADDRESS <i>525 W. Hamburg St</i>	
23C. DATE SIGNED <i>7/13/58</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>July 16 50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Mt Calvary Cem</i>		24D. LOCATION (City, town, or county) (State) <i>A. A. Co Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 13 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>Isaiah R Brown Son</i> ADDRESS <i>108 W Montgomery St</i>			

CERTIFICATE OF DEATH

10-2-01

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634

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6148

Registered No.

BIRTH NO. 6148

1. NAME OF DECEASED  
(Type or Print)

ALEXANDER L. BRADLEY  
(JOSEPH)

2. DATE  
OF  
DEATH

7-12-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Md.

BALTIMORE

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR THE location)  
INSTITUTION UNION MEMORIAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

9-03

c. Length of stay in Baltimore ALL LIFE . 64 yrs

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

728 E 35TH ST.

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

1886

9. AGE (In years

last birthday)

64

If Under 1 Year

Months

Days

If Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

CARPENTER

10B. KIND OF BUSINESS OR  
INDUSTRY

FOREMAN

11. BIRTHPLACE (State or foreign country)

BALTIMORE

12. CITIZEN OF  
WHAT COUNTRY?

USA.

13. FATHER'S NAME

Andrew Bradley

14. MOTHER'S MAIDEN NAME

Margarete Driscoll

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

SON - BERNARD L.

728 E 35TH

18. 420.1 I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CORONARY THROMBOSIS

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

1 hr 35 MIN

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROTIC HEART DISEASE

DUE TO

NOT KNOWN

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

22. I hereby certify that I attended the deceased from July 12, 1950, to July 12, 1950, that I last saw the  
deceased alive on July 12, 1950, and that death occurred at 1:05 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Alfred S. Nelson

23B. ADDRESS

M. D. The Union Memorial Hospital

23C. DATE SIGNED

July 12, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/15/50

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town or county)

Baltimore

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John A. Moray

3000 E. Balto. St.

CONTINUATION OF DEATH

2





652  
50 6149

FRANCK

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6149  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MR. E. ROSS FRANCIC</b>		2. DATE OF DEATH <b>July 12, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>Baltdo. Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mary Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 9-03</b>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>631 E. 37th St.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, <input checked="" type="checkbox"/> <b>CARRIED</b> WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Feb. 15, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Knitwear</b>	
13. FATHER'S NAME <b>John Franck</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>W. Robert Franck</b>		ADDRESS <b>631 E. 37th St.</b>	

18. <b>541.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Gastro intestinal hemorrhage (cause unknown)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>
DUE TO				
ANTECEDENT CAUSES				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____		(over)
DUE TO				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <b>Coronary thrombosis (possible)</b>		

19a. DATE OF OPERATION <b>7/15/50</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21d. TIME (Month) (Day) (Year) (Hour) INJURY _____		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>July 6, 1950</b> , to <b>July 12, 1950</b> , that I last saw the deceased alive on <b>July 12, 1950</b> , and that death occurred at <b>4:00 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>J.S. Kuehn</b>		M. D. _____		23b. ADDRESS <b>Mary Hospital</b>	
23c. DATE SIGNED <b>July 12, 50</b>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7/15/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
24d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) _____			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>John A. Moran</b>	
VS 150		ADDRESS <b>3000 E. Baltimore St.</b>			

MEDICAL CERTIFICATION

4904B 117B

ask if result of  
autopsy showed  
cause of gastro  
intestinal hemorrhage?

cause of gastro intestinal hemorrhage -  
was "old perforated duodenal ul"

See Document File  
50-6149

8-24-50  
ES

536  
6150

CERTIFICATE CORRECTED 3-12-51

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6150

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MRS. EMMA A. Anderson

2. DATE  
OF  
DEATH

7/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland B

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

BON SECOURS Hosp

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

Life

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Saleslady

10B. KIND OF BUSINESS OR  
INDUSTRY

Bakery

13. FATHER'S NAME

Henry A. Kummer

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

763 Edgewood St.

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

16-08

D. STREET ADDRESS (If rural, give location)

763 Edgewood St.

8. DATE OF BIRTH

May 12, 1885

65

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Johanna Eschman

17. INFORMANT

Miss Geneva T. Anderson, 763 Grantley St.

Edgewood St.  
ADDRESS

18. 193X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Brain Tumor  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 6, 1950, to July 12, 1950, that I last saw the  
deceased alive on July 7, 1950, and that death occurred at 7:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 13 1950

William H. Williams, Jr.

Harry H. Wirth 4101 Edmondson Ave

*Spongioblastoma polare.*

Letter in document file 50-6150-

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6151  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Allen J. GRIFFIN</b>		2. DATE OF DEATH <b>July 11, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>West Baltimore General Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>27-18</b>	
c. Length of stay in Baltimore <b>10 yrs. 6 mos.</b>		D. STREET ADDRESS (If rural, give location) <b>5015 Reisterstown Road</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>37</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Griffin Bros.</b>	
13. FATHER'S NAME <b>Martin E. Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Minnie M. Fox</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS <b>Mrs. Myrtle V. Griffin, 5015 Reisterstown Rd.</b>	

18. **E935J**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) **Electrocution by lightning**

OR TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

OR TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

**Street**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

**Front of 5110 Gwynn Oak Avenue** **28/2**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**July 11, 1950 ? P.m.**

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

**Struck by lightning**

22. I certify that I took charge of the remains described above, held an **Insp. & Inquiry** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

**Stanley B. Durlacher M.D.**

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

**7-12-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**Removal**

24B. DATE

**July 13/50**

24C. NAME OF CEMETERY OR CREMATORY

**Oakgrove**

24D. LOCATION (City, town, or county) (State)

**near Culpepper, Va.**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Jul 13 1950**

VS 151

25. FUNERAL DIRECTOR

ADDRESS

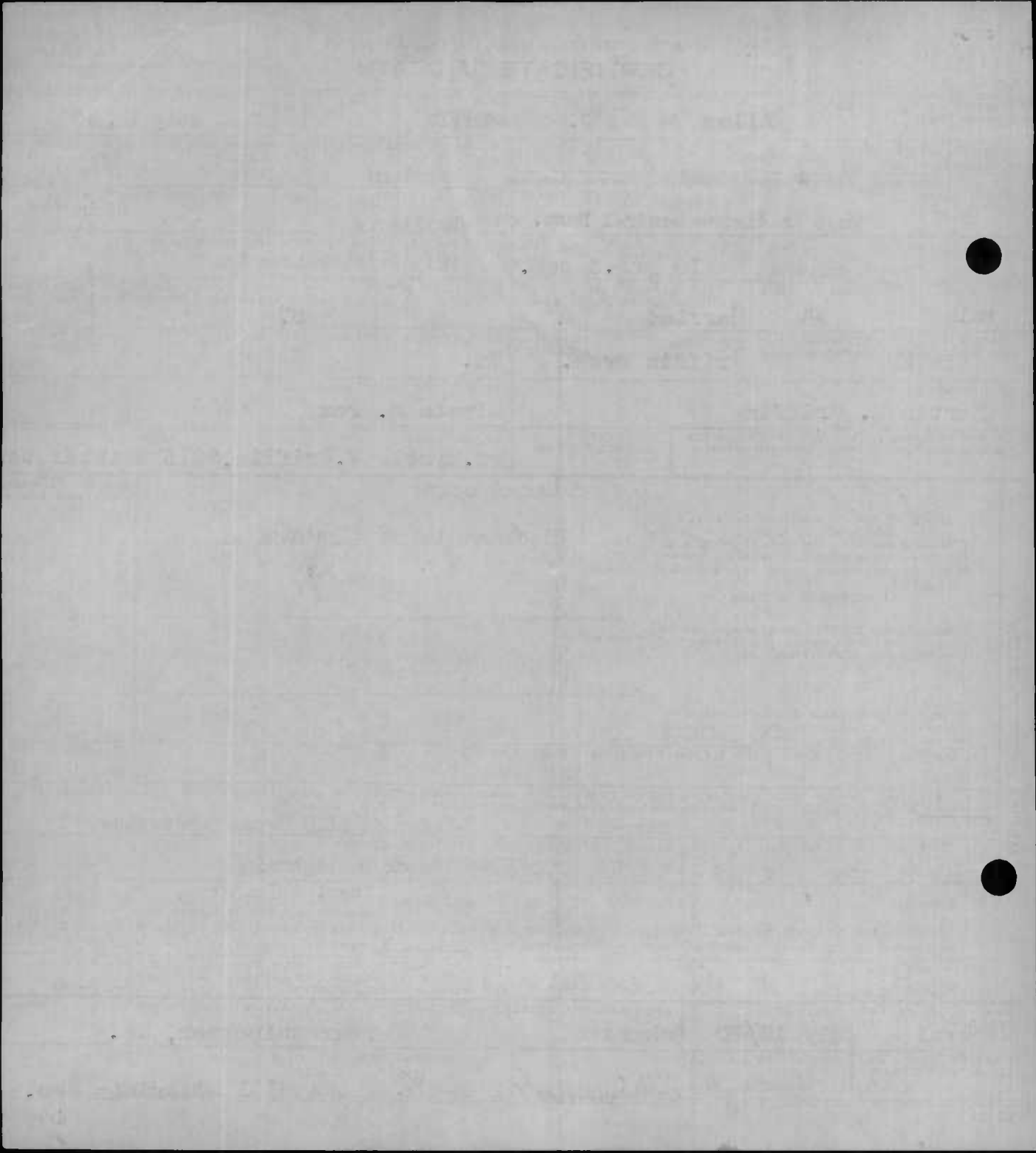
**Thurston Williams, Harry A. Lutz, 4101 Edmondson Ave.**

**N-984X**

**56424**

**192**

MEDICAL CERTIFICATION





262  
6152

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6152

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Bentlak M. Dickerson</i>		2. DATE OF DEATH <i>July 12 - 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>439 S. Bentlak St</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 20-05</i>	
c. Length of stay in Baltimore <i>35 yrs -</i>		D. STREET ADDRESS (If rural, give location) <i>439 S. Bentlak St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug. 10 - 1904</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>45</i>
13. FATHER'S NAME <i>James Howe</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <i>Edna Conwell</i>	
17. INFORMANT <i>Mr. Wm. P. Dickerson</i>		ADDRESS <i>439 S. Bentlak St</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>171X</i>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <i>Carcinoma of Cervix - Spreads to Bladder</i>		<i>7 mo</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <i>Secondary Metastasis</i>		<i>9 mo</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 3</i> , 19 <i>50</i> , to <i>July 12</i> , 19 <i>50</i> that I last saw the deceased alive on <i>Jan 3</i> , 19 <i>50</i> , and that death occurred at <i>11:00</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>E. W. Brown</i>		23B. ADDRESS <i>112 S. Calver</i>		23C. DATE SIGNED <i>July 12/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-15-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Londondale Park</i>	
24D. LOCATION (City, town or county) <i>Baltimore Ind.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 13 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm. H. Williams, M.D.</i>	
24G. FUNERAL DIRECTOR <i>Geo. E. Beyer Jr</i>		24H. ADDRESS <i>1512 N. Hollins</i>		24I. BALD. 23 Ind. <i>48a</i>	

Dr. Carl Hoona  
1202 St. Paul St.

1202 Paul St.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6153

Registered No. \_\_\_\_\_

BIRTH NO. 6153

1. NAME OF DECEASED  
(Type or Print)

*JAMES D. MASK*

2. DATE  
OF  
DEATH

*7-12-50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Lombard & Greene St*

B. FULL NAME OF HOSPITAL OR INSTITUTION *University Hospital*

C. Length of stay in Baltimore *45 yrs*

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Married*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Bottler*

10B. KIND OF BUSINESS OR INDUSTRY

*Brewery*

13. FATHER'S NAME

*John A. Mask*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*214-01-9344*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

*Maryland*

B. COUNTY

C. CITY OR TOWN

*Baltimore*

D. STREET ADDRESS (If rural, give location)

*510 Rossiter Ave*

9. AGE (In years last birthday)

*45*

11. BIRTHPLACE (State or foreign country)

*Baltimore Ind*

12. CITIZEN OF WHAT COUNTRY?

*United States*

14. MOTHER'S MAIDEN NAME

*Mary P. Perciotti*

17. INFORMANT

*Mrs. Cora J. Mask*

ADDRESS

*510 Rossiter Ave*

18. *191X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) *undetermined - anoxemia?*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Cerebral edema.*

DUE TO

(C) *Carcinoma face (sq. cell)*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

*7-7-50*

19B. MAJOR FINDINGS OF OPERATION

*elective nerve section*

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6-30*, 19*50*, to *7-12*, 19*50*, that I last saw the deceased alive on *7-12*, 19*50*, and that death occurred at *10:30 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE

*Domenico Licholob*

23B. ADDRESS

*University Hospital*

23C. DATE SIGNED

*7-12-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*7-15-50*

24C. NAME OF CEMETERY OR CREMATORY

*Holy Redeemer*

24D. LOCATION (City, town, or county) (State)

*Belair Rd. Balt Ind*

DATE RECEIVED BY LOCAL REGISTRAR

*JUL 13 1950*

REGISTRAR'S SIGNATURE

*Thurston Williams, M.D.*

25. FUNERAL DIRECTOR

*Geo. R. Beyers, 1512 Hollins St*

ADDRESS

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

256 30 6154

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6154

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WALTER WOESSNER</b>		2. DATE OF DEATH <b>July 12, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Texas</b> B. COUNTY <b>Harris</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>306 Birkwood Place</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Houston</b>			
C. Length of stay in Baltimore <b>21</b> Days		D. STREET ADDRESS (If rural, give location) <b>Hotel Cotton</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>Sept. 13, 1868</b>	9. AGE (In years last birthday) <b>81</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practitioner</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Christian Science</b>		11. BIRTHPLACE (State or foreign country) <b>Corpus Christi, Texas</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Woessner</b>			
14. MOTHER'S MAIDEN NAME <b>Fannie (?)</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT ADDRESS <b>Mrs. A. W. McCallan, 306 Birkwood Place</b>			

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Heart Disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an <u>Inspection &amp; Inquiry</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <b>Stanley H. Dundalk</b> M.D.	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED <b>July 12, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/15/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Forest Park</b>
24D. LOCATION (City, town, or county) <b>Houston, Texas</b>		(State)

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 13 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Walter Brooks Bradley</b>	ADDRESS <b>Dundalk, MD</b>
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937

CERTIFICATE OF DEATH

With Love & Affection



426

50 6155

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6155  
Registered No.

BIRTH NO. 50 6155		2. DATE OF DEATH July 10, 1950	
1. NAME OF DECEASED (Type or Print) GEORGE WALKER			
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-04	
B. FULL NAME OF HOSPITAL OR INSTITUTION 624 N. Brice Street		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 624 N. Brice Street	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH July Dec. 17, 1892
9. AGE (In years last birthday) 57	10. UNDER 1 Year Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) Ind.	12. CITIZEN OF WHAT COUNTRY? U.S.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10B. KIND OF BUSINESS OR INDUSTRY <u>Amusement States</u>	
13. FATHER'S NAME John Walker		14. MOTHER'S MAIDEN NAME Annie Eichorn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) yes W.W. #1		16. SOCIAL SECURITY NO. —	
17. INFORMANT Wm. Walker - 625 N. Brice St.		ADDRESS	

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Coronary thrombosis	INTERVAL BETWEEN ONSET AND DEATH few hours
DUE TO			
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B)	
DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 10, 1950, to July 10, 1950, that I last saw the deceased alive on July 10, 1950, and that death occurred at 11:30 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Louis T. Kany		23B. ADDRESS 1844 W. North Avenue		23C. DATE SIGNED July 13 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7-14-50		24C. NAME OF CEMETERY OR CREMATORY Balto. National	
24D. LOCATION (City, town, or county) Balto.		24E. LOCATION (State) Md.			
DATE RECEIVED BY LOCAL REGISTRAR JUL 13 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR George A. Farley	
VS 150				ADDRESS	

5006A

94a

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH  
OFFICE OF VITAL RECORDS

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50 6156

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 6156  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Edith Wamsley</i>		2. DATE OF DEATH <i>7-13-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>W. VA.</i> B. COUNTY <i>V-45</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hosp. of Maryland</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>ELKINS</i>	
D. STREET ADDRESS (If rural, give location)			
5. LENGTH OF STAY IN BALTIMORE <i>3 Wks</i>		Yrs. Mos. Days	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>17 NOV 1878</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	9. AGE (In years last birthday) <i>71 72</i>
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Miss Wamsley Elkins</i>		ADDRESS	

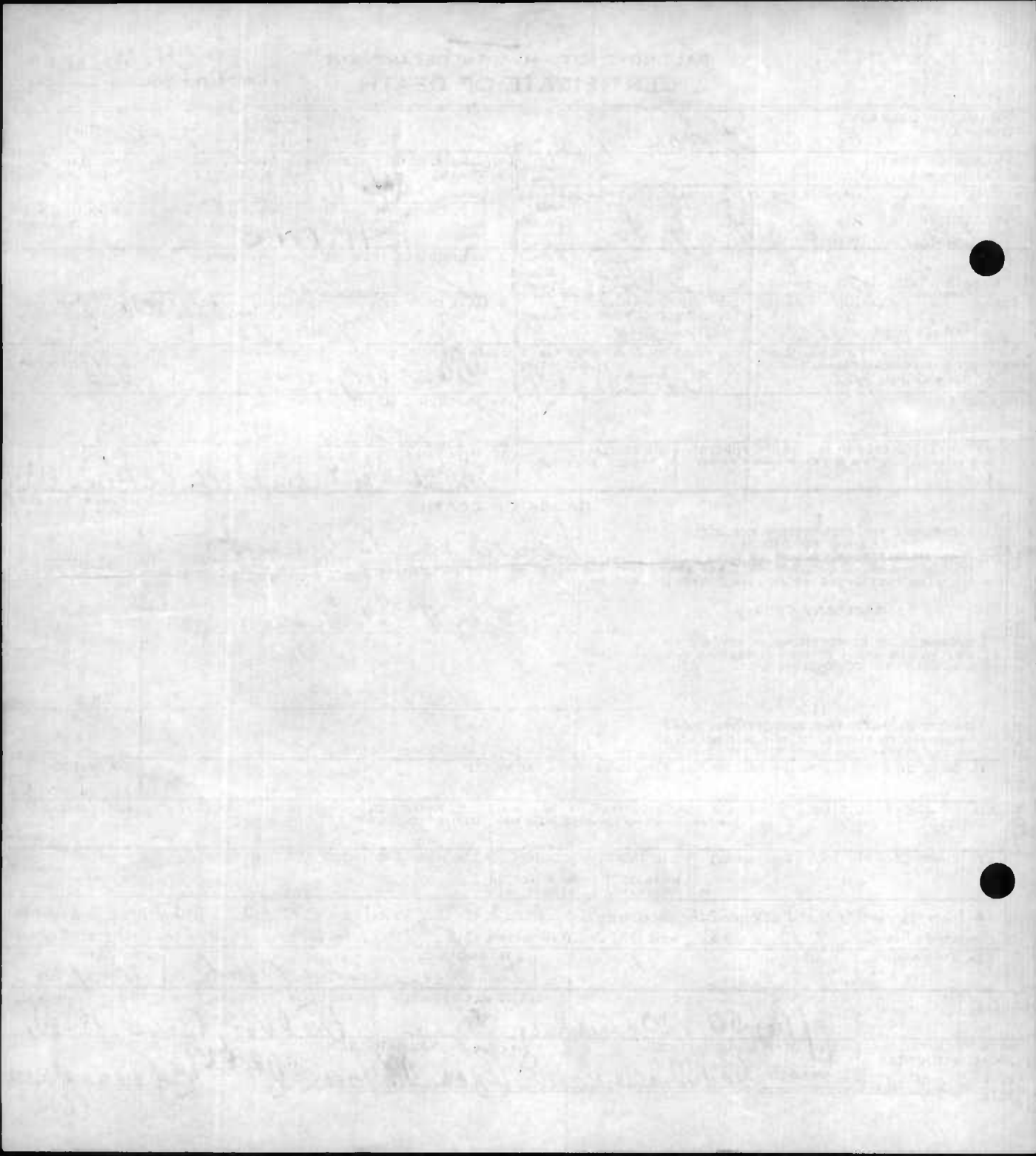
18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TO  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  DUE TO  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cerebral Vascular Accident</i> DUE TO (B) <i>Generalized arteriosclerosis</i> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *6-28*, 1950 to *7-13*, 1950 that I last saw the deceased alive on *7-13*, 1950, and that death occurred at *5<sup>45</sup>A* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Stanley R. Meischel</i>		23B. ADDRESS <i>Lutheran Hosp &amp; Ind</i>		23C. DATE SIGNED <i>7/13/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <i>7/16/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Wamsley Ceme</i>	24D. LOCATION (City, town, or county) (State) <i>Elkins W. Va.</i>	25. FUNERAL DIRECTOR <i>Edmondson</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		REGISTRAR'S SIGNATURE <i>Christington Williams, Jr.</i>		

VS 150  
832 Ave



35 50 6157

50 6157

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Jo Messing Harding</i>		2. DATE OF DEATH <i>July 13, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>St. Marys</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Leonardtown 6800</i>	
C. Length of stay in Baltimore <i>3 days</i>		D. STREET ADDRESS (If rural, give location) <i>R.F.D. #1.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>5-19-88</i>
9. AGE (In years last birthday) <i>62</i>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Marion, Indiana</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Rabbi Mayer Messing</i>		14. MOTHER'S MAIDEN NAME <i>Ricca Taphtali</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL - Jack Harding</i>			

18. <i>331X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Cerebral hemorrhage</i> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) DUE TO		

19A. DATE OF OPERATION <i>7-13-50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-11</i> , 19 <i>50</i> , to <i>7-13</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-13</i> , 19 <i>50</i> , and that death occurred at <i>7:30 p.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>James C. Vandell, Jr.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>7-13-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>July 17, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Florence Buchanan Crematory</i>	
24D. LOCATION (City, town, or county) <i>Indianapolis, Ind.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	
24G. FUNERAL DIRECTOR <i>H.C. Mattingly &amp; Sons</i>		24H. ADDRESS <i>Leonardtown md.</i>		24I. SIGNATURE <i>per L. Maguire Mattingly, Jr. 83a</i>	

MEDICAL CERTIFICATION

11



11





CONFIDENTIAL - SECURITY INFORMATION

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

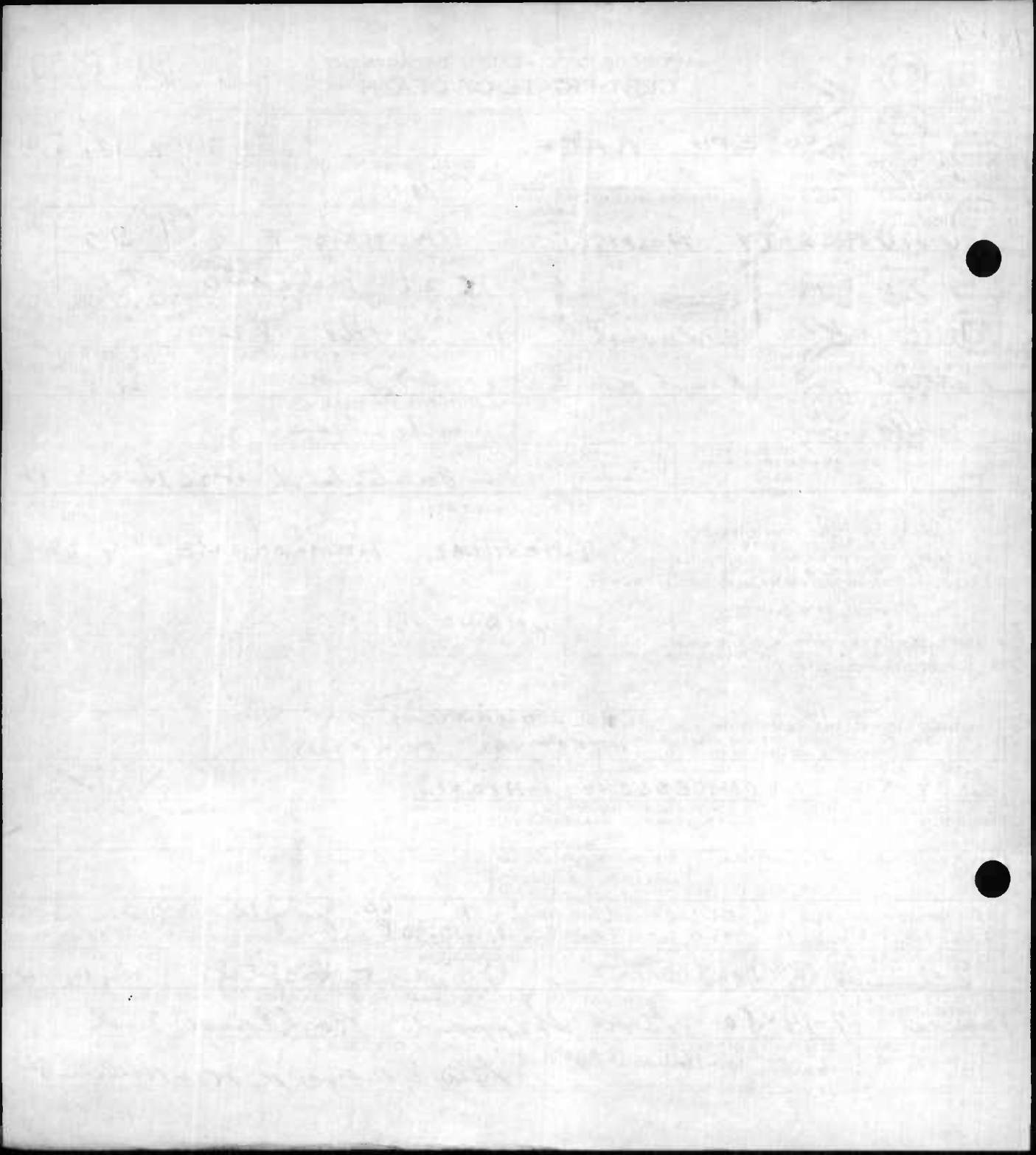
Registered No. 50 6159

1. NAME OF DECEASED (Type or Print) <b>JOSEPH GABE</b>		2. DATE OF DEATH <b>JULY 12, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 19-03</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1526 HOLLAND ST.</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. <del>SINGLE</del> MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>March - 1868</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pench room</b>	9. AGE (In years last birthday) <b>82</b>
13. FATHER'S NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Fautenburgh 1526 Holland St</b>		ADDRESS	

18. <b>584X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>INTESTINAL HEMORRHAGE</b> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>UNKNOWN</b> DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <b>CHOLEDOCHYSTOMY POST OP. INTESTINAL POLYPOSIS</b>	
19A. DATE OF OPERATION <b>6-24-50</b>	19B. MAJOR FINDINGS OF OPERATION <b>CHOLEDOCHOLITHIASIS</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **July 1, 1950** to **July 12, 1950**, that I last saw the deceased alive on **July 12, 1950**, and that death occurred at **10:50 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Edmund B. Middleton</b> M. D.		23B. ADDRESS <b>University Hospital</b>		23C. DATE SIGNED <b>July 13, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-14-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Good Sheppard</b>	24D. LOCATION (City, town, or County) (State) <b>Rockland Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>		
25. FUNERAL DIRECTOR <b>Geo. E. Bayer Jr</b>		ADDRESS <b>1512 Hollins St</b>		



242  
REA-39451BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6160  
Registered No.

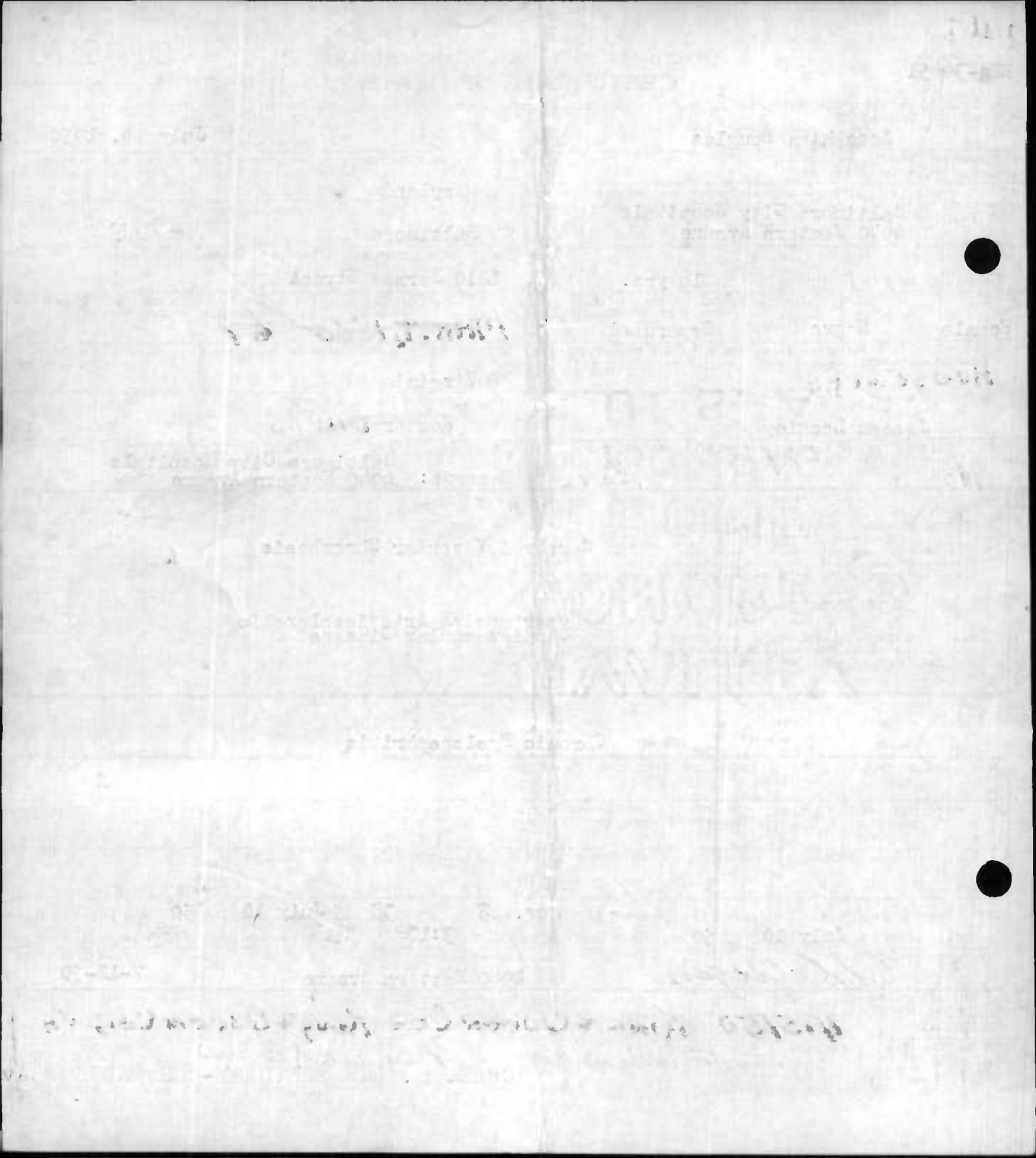
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Josephine Douglas</b>		2. DATE OF DEATH <b>July 10, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>10-02</b>	
c. Length of stay in Baltimore <b>18 yrs.</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1210 Barnes Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Separated</b>	8. DATE OF BIRTH <b>MAR. 4, 1883</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (in years last birthday) <b>67</b>
13. FATHER'S NAME <b>Joseph Lockley</b>		14. MOTHER'S MAIDEN NAME <b>Hester DAVIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
		17. INFORMANT ADDRESS <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Avenue</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Thrombosis</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO CHRONIC PYELONEPHRITIS	CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <b>7-15-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>Nov. 28</b> , 1938, to <b>July 10</b> , 1950, that I last saw the deceased alive on <b>July 10</b> , 1950, and that death occurred at <b>3:10Pm.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>C. R. Law</b>		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>7-12-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>7/15/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>KING + QUEEN CEM</b>	24D. LOCATION (City, town, or county) (State) <b>KING + QUEEN CEM VA.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>	REGISTRAR'S SIGNATURE <b>William M. Law</b>	25. FUNERAL DIRECTOR <b>CHAS. R. LAW MORTUARY-802 MADISON AV</b>	





530  
0 6161BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

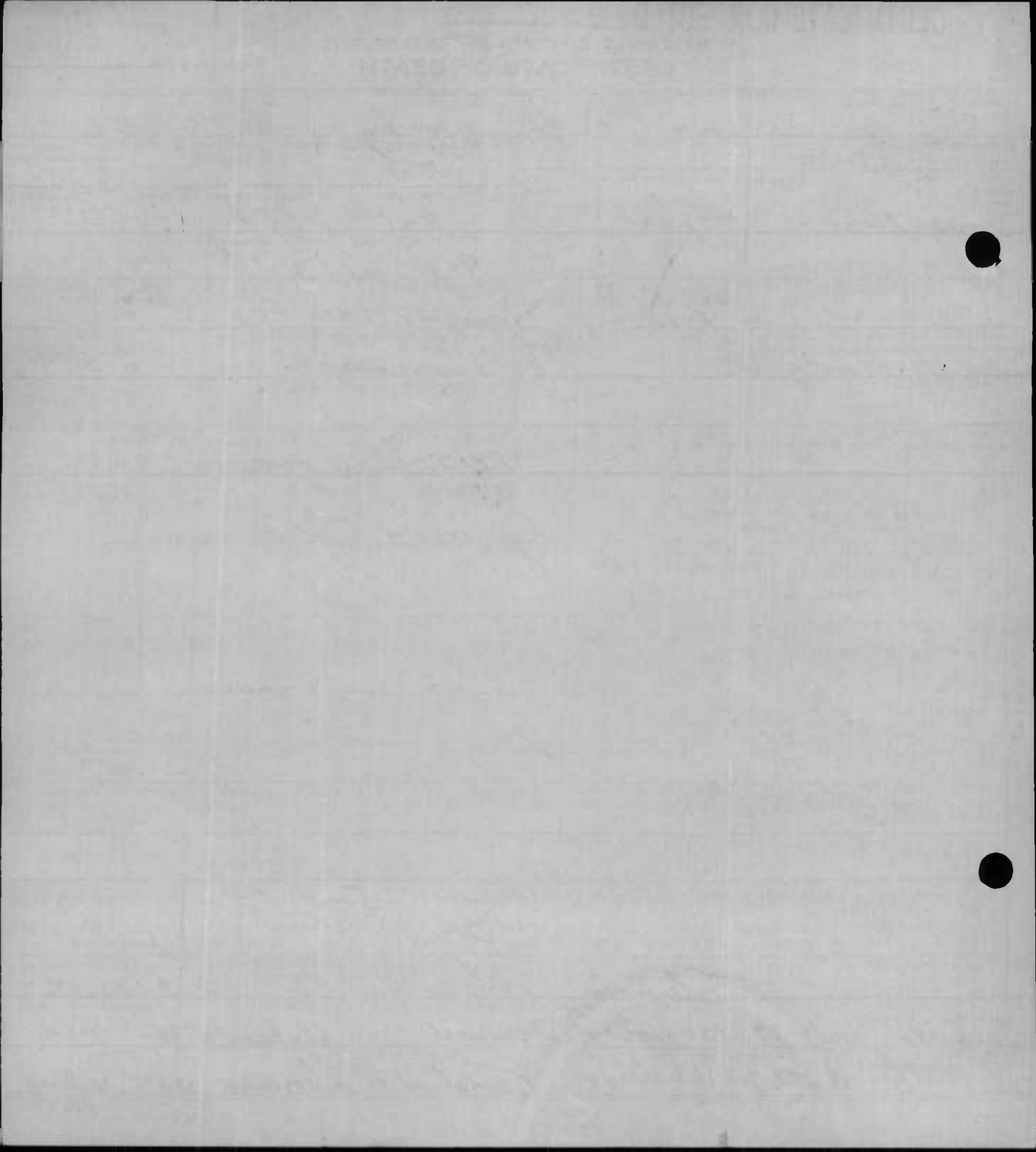
Registered No. 50 6161

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		MARY ELIZABETH SMITH		July 13, 1950	
3. PLACE OF DEATH:		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
A. Baltimore City, Maryland		A. STATE			
BALTIMORE, MD.		MARYLAND			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
HOSPITAL for the Women of MARYLAND		BALTIMORE 15-05			
4. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
Yrs. Mos. Days		3408 Hill Dale PLACE			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10 Under 1 Year Months: Days
Female	White	WIDOWED	4-9-65	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Housewife		—	? MARYLAND		U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
FRANK PELTZER		?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		
No		—	MRS. GRACE JONES 3408 Hill Dale PLACE		
18. 561.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(A) Myocardial Insufficiency			?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
		(B) Spontaneous release of intestinal obstruction			4 days
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) strangulated inguinal hernia; cerebral thrombosis; bilateral lower nephron nephrosis			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?
7-11-50		INCARCERATED Richter's hernia, left			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		—		—	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
—		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		—	
22. I hereby certify that I attended the deceased from July 11, 1950, to July 13, 1950, that I last saw the deceased alive on July 13, 1950, and that death occurred at 4 <sup>35</sup> A. m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Eben T. Bennett M.D.		Women's Hospital		July 13, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 15/50		All. Saints	
24D. LOCATION (City, town, or county)		24E. NAME OF CEMETERY OR CREMATORY		24F. LOCATION (City, town, or county)	
Ruststown Md.		Ruststown		Ruststown Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
JUL 14 1950		Huntington Williams, M.D.		J. F. Eline Sons Ruststown Md.	

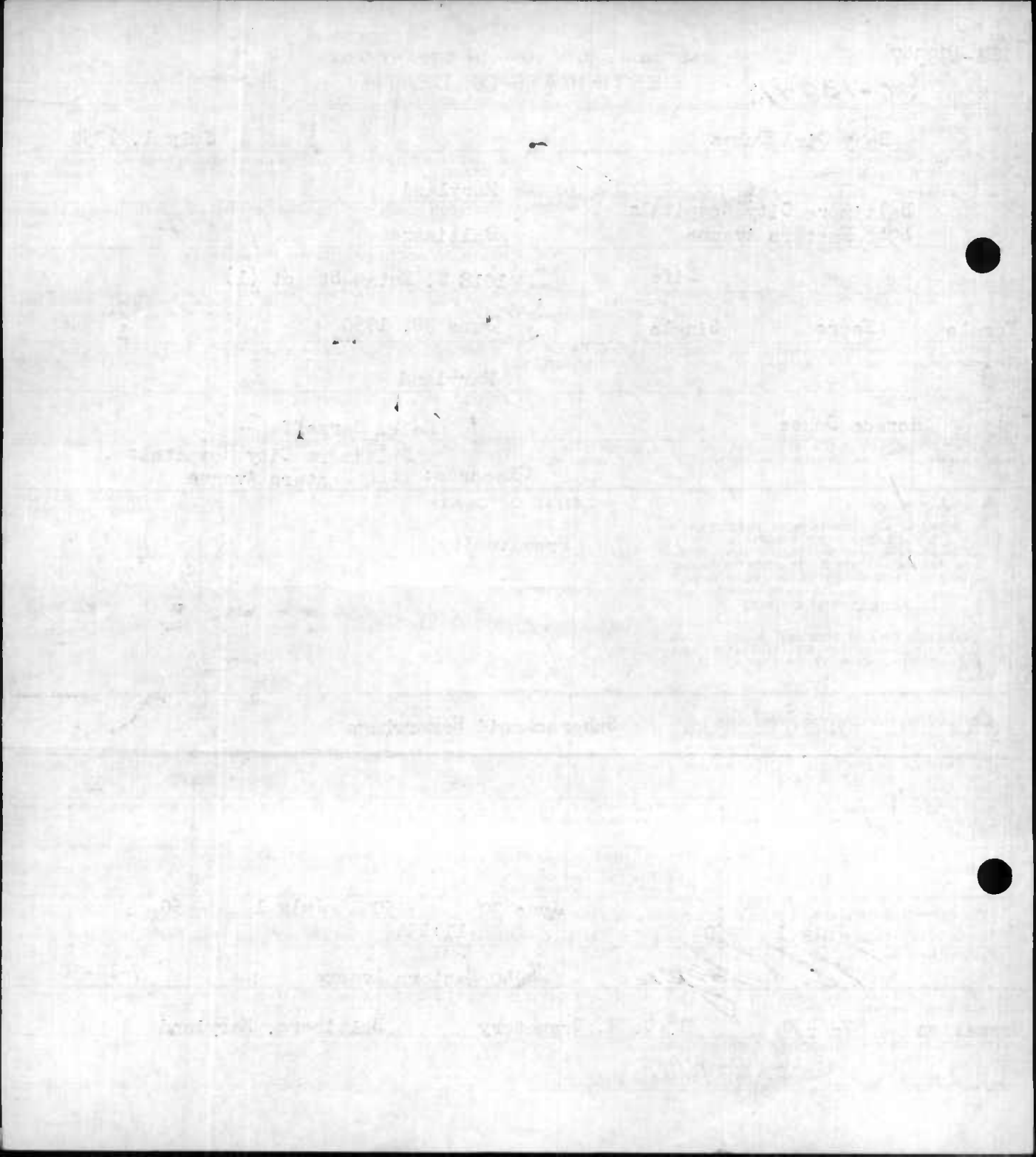


1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Lucille M. Dowdy		7/13/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE	
Venerable Memorial Hospital		Md	
C. Length of stay in Baltimore		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Yrs. Mos. Days		Baltimore Md 13-05	
5. SEX		D. STREET ADDRESS (If rural, give location)	
F		819 W. 33rd St	
6. COLOR OR RACE		8. DATE OF BIRTH	
W		June 27, 1891	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		9. AGE (In years last birthday)	
Widow		59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Housewife		Virginia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
?		?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		17. INFORMANT	
-		Forwood	
16. SOCIAL SECURITY NO.		ADDRESS	
-		BEATRICE M. FORWARD - 819 W 33rd St	

18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) DUE TO		Hypertensive C.V. Disease			
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
0				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
m.					
22. I certify that I took charge of the remains described above, held an <u>Examination</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE		23B. CHIEF MEDICAL EXAMINER		23C. DATE SIGNED	
R.P. Lubinski		M.D.		7/13/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 17/50		Holy Redeemer	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
JUL 14 1950		Christington Williams, Jr.		Belair Rd. Md	
				ADDRESS	
				Martin E. Sonoran 3518 Roland	



50. 6163		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. _____	
REA-139347 BIRTH NO. 50-13247					
1. NAME OF DECEASED (Type or Print) <b>Baby Girl Dukas</b>			2. DATE OF DEATH <b>July 1, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1018 N. Eutaw Street (1)</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 30, 1950</b>		9. AGE (In years last birthday) <b>1</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Horace Dukas</b>			14. MOTHER'S MAIDEN NAME <b>Helen Barneff</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMATION <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Avenue</b>	
18. <b>774X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>Prematurity</b> DUE TO (A) _____  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) _____  (C) _____			CAUSE OF DEATH  INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  <b>Subarachnoid Hemorrhage</b>					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 30</b> , 19 <b>50</b> , to <b>July 1</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 1</b> , 19 <b>50</b> , and that death occurred at <b>11:15A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS M. D. <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>7-6-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>B. C. H. Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR ADDRESS	





509 Hospital Disposition 50-13254		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 6164 Registered No.
1. NAME OF DECEASED (Type or Print) <b>Baby Boy ROWAN A-78946</b>		2. DATE OF DEATH <b>JUL 10 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
C. Length of stay in Baltimore		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, 3-02</b>		
5. SEX <b>male</b>		D. STREET ADDRESS (If rural, give location) <b>34 S. Lloyd St.</b>		
6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>baby</b>	8. DATE OF BIRTH <b>6-28-50</b>	9. AGE (In years last birthday)	10. Under 1 Year Months: Days: <b>12</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME <b>Roy H. Rowan</b>		
14. MOTHER'S MAIDEN NAME <b>Elsie</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b> ADDRESS		
18. <b>760.5</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intracranial hemorrhage</b> DUE TO (A) ANTECEDENT CAUSES <b>Prematurity</b> DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>7-10-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>6-28-</b> , 19 <b>50</b> to <b>7-10-</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-10-</b> , 19 <b>50</b> , and that death occurred at <b>100A</b> m., from the causes and on the date stated above.				
23A. SIGNATURE <b>Henny M. Seidel</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>July 10, 1950</b>
24A. BURIAL, CREMA- TION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY <b>Hope Deforest</b>	24D. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>	REGISTRAR'S SIGNATURE <b>Arthur J. Williams, M.D.</b>	25. FUNERAL DIRECTOR		ADDRESS

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance and that it has not been completely solved. The author then proceeds to a detailed analysis of the problem, showing that it is in fact a special case of a more general problem. This analysis leads to the conclusion that the problem is solvable and that the solution is unique. The author then gives a brief summary of the results and discusses some of the open questions. Finally, the author gives a list of references.

1955

## BALTIMORE CITY HEALTH DEPARTMENT

50 6165

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BABY GIRL CURRIE "A"

2. DATE  
OF  
DEATH

July 6, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNION MEMORIAL HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto.

12-02

D. STREET ADDRESS (If rural, give location)

3222 St. Paul St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

July 4, 1950

9. AGE (In years;  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.

2

11

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JAMES W. CURRIE

14. MOTHER'S MAIDEN NAME

BILLIE CONOLLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMATURITY (LESS THAN 27 WKS.)

2 DAYS 11 HRS.

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22. I hereby certify that I attended the deceased from July 4, 1950, to July 6, 1950, that I last saw the deceased alive on July 6, 1950, and that death occurred at 11:02 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Richard R. Beach

M. D.

23B. ADDRESS

Union Memorial Hosp.

23C. DATE SIGNED

7-7-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-8-50

24C. NAME OF CEMETERY OR CREMATORY

Union Memorial Hospital

24D. LOCATION (City, town, or county)

Balto.-18, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Harcy M. Ceman, Dept of

VS 150

(with parents written permission) Pathology,  
159

MEDICAL CERTIFICATION

RECEIVED BY THE  
DEPARTMENT OF  
THE ARMY

10. 1. 1944

1. 1. 1944

1. 1. 1944

1. 1. 1944

1. 1. 1944

1. 1. 1944

1. NAME OF DECEASED (Type or Print) Baby Girl Currie "B"		2. DATE OF DEATH July 4, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md. b. COUNTY	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Union Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 12-02	
c. Length of stay in Baltimore Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) 3222 St Paul St	
5. SEX F	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH July 4, 1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME James W. Currie		14. MOTHER'S MAIDEN NAME Billie Conolley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT ADDRESS	

18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  IMMATUREITY - less than 27 weeks.  DUE TO  DUE TO  DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH 6 hr. 21 min.
19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 4, 1950, to July 4, 1950, that I last saw the deceased alive on July 4, 1950, and that death occurred at 5:10 Pm., from the causes and on the date stated above.					
23a. SIGNATURE Robert Davis Jr		23b. ADDRESS M. D. Union Memorial Hospital		23c. DATE SIGNED July 9, 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) cremated		24b. DATE 7-5-50		24c. NAME OF CEMETERY OR CREMATORY Union Memorial Hospital	
24d. LOCATION (City, town, or county) (State) Balto - 18, Md.		24e. DATE RECEIVED BY LOCAL REGISTRAR III 14 1950		24f. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
24g. FUNERAL DIRECTOR Nancy M. Curran, Dept. of 159		24h. ADDRESS Pathology.		(with parents written permission)	

STATE OF CALIFORNIA  
CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician	
11. Signature of Registrar		12. Signature of Coroner		13. Signature of Medical Examiner		14. Signature of County Clerk		15. Signature of State Registrar	



361

6167

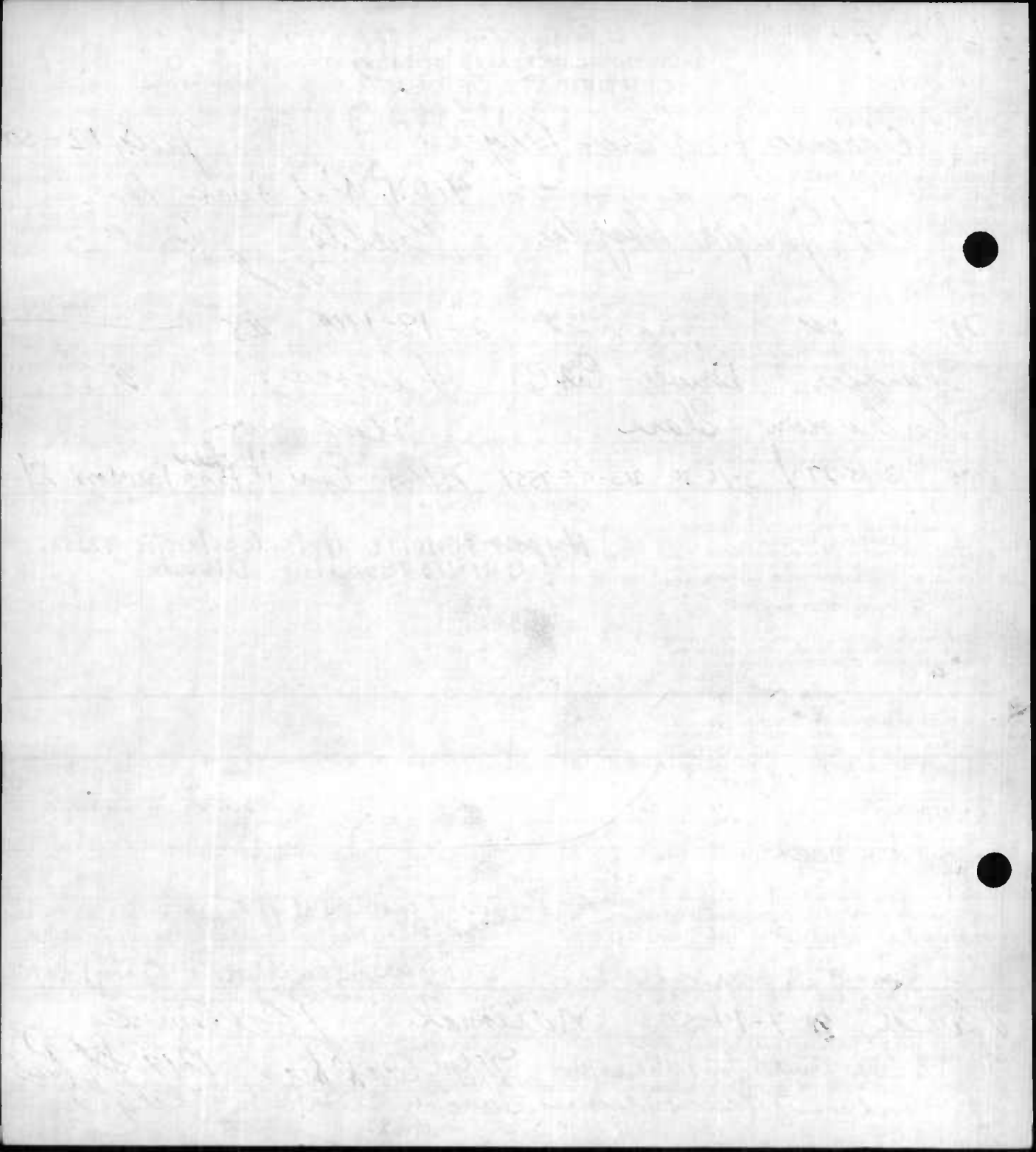
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6167

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Clarence J. Stare - Bryce</i>		2. DATE OF DEATH <i>July 12 - 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>4104 Pat. Park Ave</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>6-03</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH <i>2-18-1904</i>	
9. AGE (In years last birthday) <i>46 45</i>		10. UNDER 1 Year Months: Days	
11. BIRTHPLACE (State or foreign country) <i>Penna.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown - Stare</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>213-057851</i>	
17. INFORMANT <i>Mrs. Eva Hedger</i>		18. ADDRESS <i>1302 Towson St</i>	
19. DATE OF OPERATION <i>7-15-50</i>		20. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		24. TIME (Month) (Day) (Year) (Hour) INJURY	
25. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26. HOW DID INJURY OCCUR?	
27. I hereby certify that I attended the deceased from <i>July 12</i> , 19 <i>50</i> , to <i>July 14</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 12</i> , 19 <i>50</i> , and that death occurred at <i>10:30 A.M.</i> , from the causes and on the date stated above.			
28. SIGNATURE <i>Wm. H. Kammner, Jr.</i>		29. ADDRESS <i>501 Sheridan Ave.</i>	
30. DATE <i>7-14-50</i>		31. NAME OF CEMETERY OR CREMATORY <i>National</i>	
32. LOCATION (City, town, or county) <i>Baltimore</i>		33. STATE <i>Md.</i>	
34. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		35. REGISTRAR'S SIGNATURE <i>Wm. C. C. C.</i>	
36. FUNERAL DIRECTOR <i>Wm. C. C. C.</i>		37. ADDRESS <i>1217 St Paul</i>	
VS 150 <i>In lieu of Yellow Medical Examiner Certificate</i> <i>68254 to 447.</i>			

MEDICAL CERTIFICATION



536  
50 6168BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6168  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Rosa Bender</i>		2. DATE OF DEATH <i>7/11/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1909 E. North Ave</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 8-05</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1909 E. North Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	B. DATE OF BIRTH <i>Sept 12<sup>th</sup> 1862</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	9. AGE (in years last birthday) Months: Days <i>87</i>
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>John Lober</i>		14. MOTHER'S MAIDEN NAME <i>Mary Markoff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Albert Bender</i>		E. ADDRESS <i>6227 Faindell Ave</i>	

1B. <i>422.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Hemorrhage</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	CAUSE OF DEATH (A) <i>Cerebral Hemorrhage</i> DUE TO (B) <i>Arteriosclerotic Cardio-vascular disease</i> DUE TO (C)
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-30</i> , 19 <i>50</i> , to <i>7-11</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-11</i> , 19 <i>50</i> , and that death occurred at <i>2 P.</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>William H. Fusting</i>		23B. ADDRESS <i>11 S. Chesebrough St.</i>		23C. DATE SIGNED <i>7-13-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/14/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm Cook Inc. 1217 St. Paul St.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		REGISTRAR'S SIGNATURE <i>William H. Fusting</i>		25. FUNERAL DIRECTOR ADDRESS <i>Wm Cook Inc. 1217 St. Paul St.</i>	

10/11/50

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10/11/50

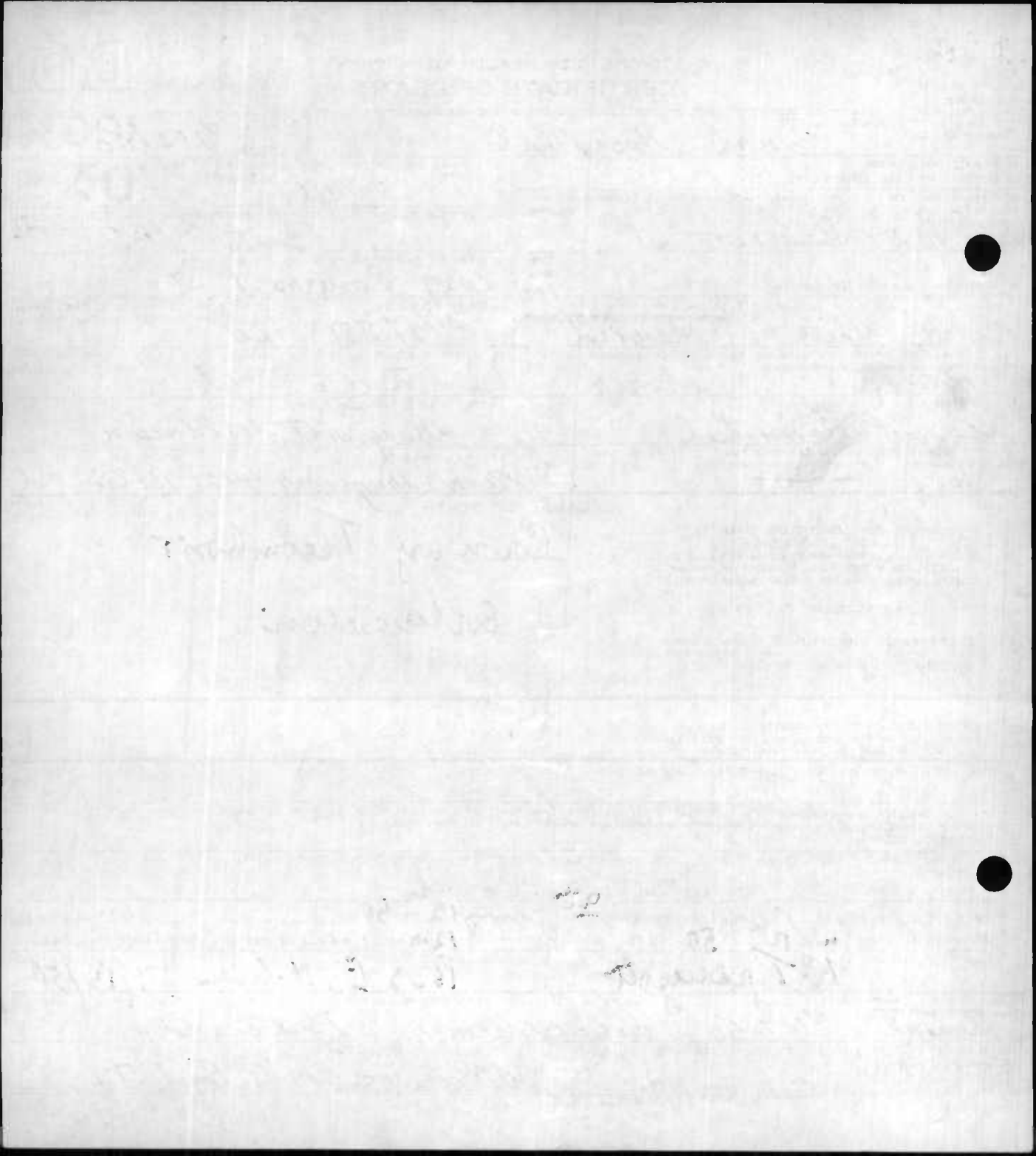
253  
50 6169  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6169  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Joseph Rosenthal</i>		2. DATE OF DEATH <i>7/13/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>Md.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1027 Somerset St</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 10-01</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1027 Somerset St</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3/19/1881</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Laborer</i>	9. AGE (In years last birthday) <i>69</i> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>August Rosenthal</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Tillman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Minnie Ingersoll 4821 Belair Rd</i>	
17. INFORMANT <i>Minnie Ingersoll</i>		ADDRESS	

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Crown artery Thrombosis</i> DUE TO (A) <i>Arteriosclerosis</i> (B) <i>Arteriosclerosis</i> (C) <i>Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH	19. DATE OF OPERATION <i>0</i> 19a. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 12, 1950</i> , to <i>July 12, 1950</i> , that I last saw the deceased alive on <i>July 12, 1950</i> and that death occurred at <i>12:00 a.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>K. T. Prougott</i>		23B. ADDRESS <i>1623 E. N. Owen</i>		23C. DATE SIGNED <i>7/13/50</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7/17/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer</i>	24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>Wm. Cok Inc. 1217 St. Paul St.</i>		ADDRESS	



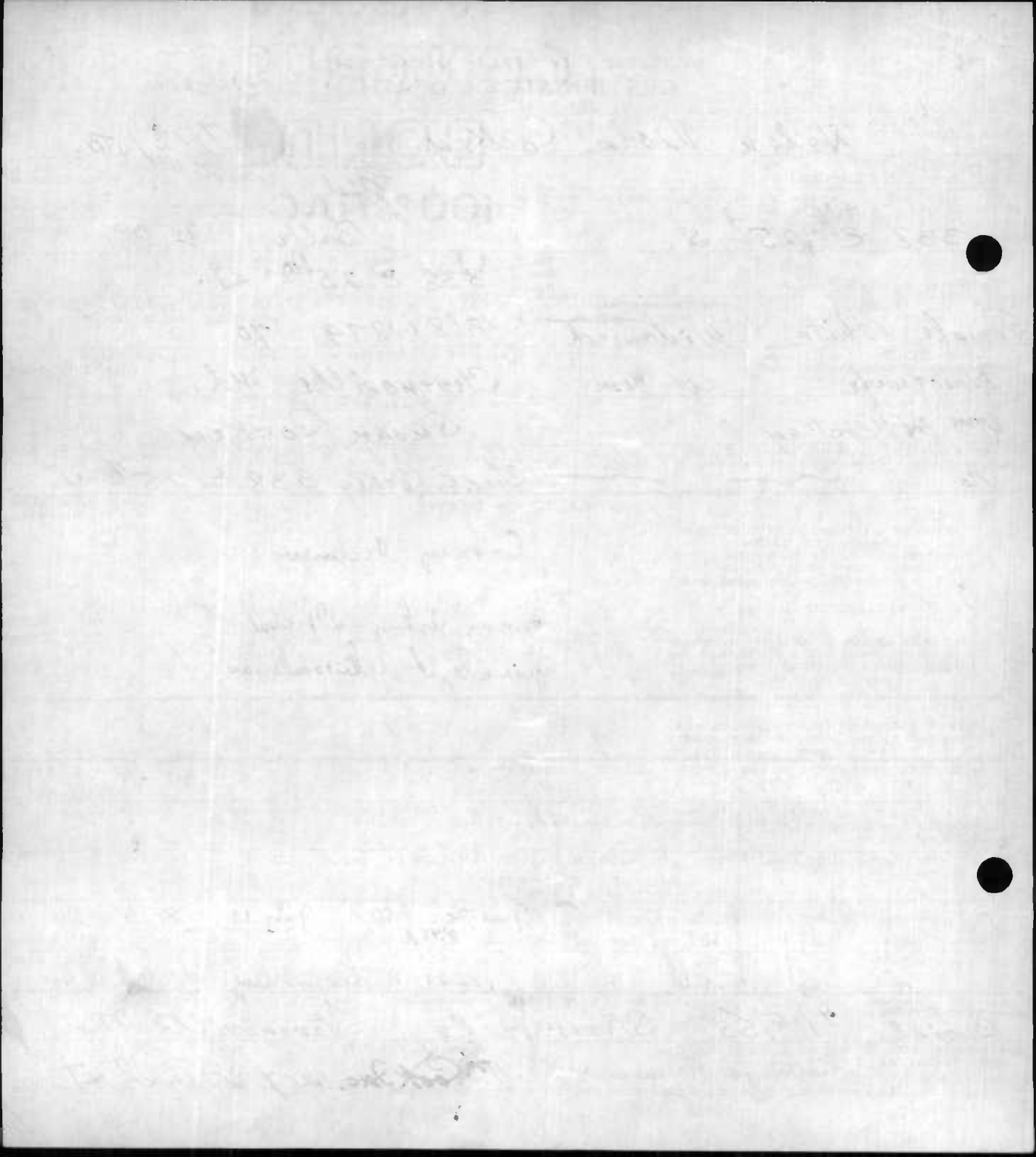


200  
50 6170BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6170

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Helen Viola Cockey</i>		2. DATE OF DEATH <i>7/13/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY			
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>338 E. 25<sup>th</sup> St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 12-03</i>			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>338 E. 25<sup>th</sup> St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>12/8/1879</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Stearnsville Md.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Wm H. Cockey</i>			
14. MOTHER'S MAIDEN NAME <i>Susan Cockey</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Chas. E. Cockey 338 E. 25<sup>th</sup> St</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i>		CAUSE OF DEATH (A) <i>Crown Artery Occlusion</i> DUE TO (B) <i>Crown Artery Disease</i> DUE TO (C) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>-</i> <i>?</i> <i>:</i>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 20, 1950</i> , to <i>July 13, 1950</i> , that I last saw the deceased alive on <i>July 11, 1950</i> , and that death occurred at <i>8:45 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Leonal Brill</i>		23B. ADDRESS <i>1221 N. Luzerne Ave</i>		23C. DATE SIGNED <i>July 13, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/15/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Stearnsville</i>	
24D. LOCATION (City, town, or county) (State) <i>Stearnsville Md</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm H. Williams</i>	
24G. FUNERAL DIRECTOR <i>Wm Cook Inc.</i>		24H. ADDRESS <i>1217 St. Paul St</i>		24I. SIGNATURE <i>94a</i>	

MEDICAL CERTIFICATION



400  
0 6171

NOEL

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6171  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mr. Robert E. Noel

2. DATE  
OF  
DEATH

July 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland Bon Secours Hosp.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION  
(If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

20-07

D. STREET ADDRESS (If rural, give location)

100 S. Morley St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1-17-15

9. AGE (In years,  
last birthday)

35

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during last 12 months, even if retired)

Service Man

10B. KIND OF BUSINESS OR  
INDUSTRY

Hoffberger Co

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Sylvester Price Noel

14. MOTHER'S MAIDEN NAME

Valerie George

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Ann L. Noel 100 S. Morley St.

18. 162 x 1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TOBronchogenic  
Carcinoma

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

(C) .....

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-23, 1950 to 7-13, 1950, that I last saw the  
deceased alive on 7-12, 1950, and that death occurred at 8:35 a.m., from the causes and on the date stated above.

23A. SIGNATURE

A. P. Rizzo

M. D.

23B. ADDRESS

Bon Secours Hosp

23C. DATE SIGNED

7-13-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/15/50

24C. NAME OF CEMETERY OR CREMATORY

Meadow Ridge

24D. LOCATION (City, town, or county)

Dorsey Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

JUL 14 1950

REGISTRAR'S SIGNATURE

Thurston William

25. FUNERAL DIRECTOR

J. M. Cook Inc. 1217 St. Paul St.

ADDRESS

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Signature of witness: \_\_\_\_\_

14. Signature of funeral director: \_\_\_\_\_

15. Signature of undertaker: \_\_\_\_\_

16. Signature of cemetery: \_\_\_\_\_

17. Signature of burial: \_\_\_\_\_

18. Signature of interment: \_\_\_\_\_

19. Signature of cremation: \_\_\_\_\_

20. Signature of other: \_\_\_\_\_

21. Signature of other: \_\_\_\_\_

22. Signature of other: \_\_\_\_\_

23. Signature of other: \_\_\_\_\_

24. Signature of other: \_\_\_\_\_

25. Signature of other: \_\_\_\_\_

26. Signature of other: \_\_\_\_\_

27. Signature of other: \_\_\_\_\_

28. Signature of other: \_\_\_\_\_

29. Signature of other: \_\_\_\_\_

30. Signature of other: \_\_\_\_\_

31. Signature of other: \_\_\_\_\_

32. Signature of other: \_\_\_\_\_

33. Signature of other: \_\_\_\_\_

34. Signature of other: \_\_\_\_\_

35. Signature of other: \_\_\_\_\_

36. Signature of other: \_\_\_\_\_

37. Signature of other: \_\_\_\_\_

38. Signature of other: \_\_\_\_\_

39. Signature of other: \_\_\_\_\_

40. Signature of other: \_\_\_\_\_

41. Signature of other: \_\_\_\_\_

42. Signature of other: \_\_\_\_\_

43. Signature of other: \_\_\_\_\_

44. Signature of other: \_\_\_\_\_

45. Signature of other: \_\_\_\_\_

56 Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6172

Registered No.

BIRTH NO. 50-14023

1. NAME OF DECEASED  
(Type or Print)

Baby Gladys Joyner

2. DATE  
OF  
DEATH

July 12, '50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2185 Federal St

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

B. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(C)

PREMATURITY

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from July 10, 1950 to July 12, 1950 that I last saw the  
deceased alive on July 12, 1950 and that death occurred at 12:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Henry M. Seidel

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

July 13, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

JUL 14 1950

VS 150

159

1000 1000 1000 1000 1000

July 10, 1900

Comptroller

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

1000 1000 1000 1000 1000

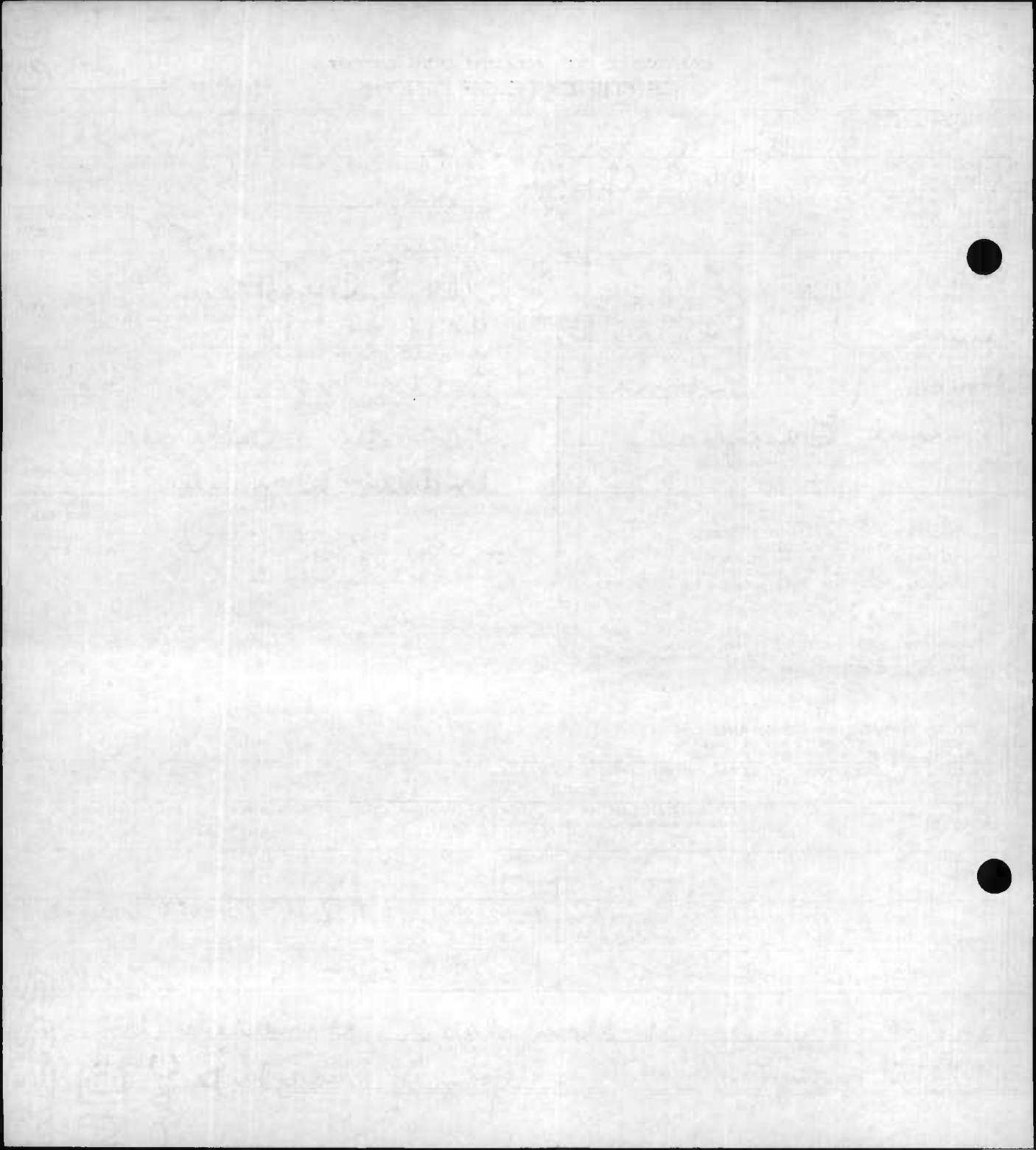
1000 1000 1000 1000 1000

1000 1000 1000 1000 1000



252  
6173BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6173  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary F. Wozniak</i>		2. DATE OF DEATH <i>7-12-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>106 S. Chester</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto.</i> <i>2-01</i>			
C. Length of stay in Baltimore <i>Life</i> <i>44</i> Yrs. <i>-</i> Mos. <i>-</i> Days		D. STREET ADDRESS (If rural, give location) <i>106 S. Chester St.</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>4-18-06</i>	9. AGE (In years last birthday) <i>44</i>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Vincent Gaczynski</i>		14. MOTHER'S MAIDEN NAME <i>Frances Mallesner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT ADDRESS <i>Andrew Wozniak 106 S. Chester</i>	
18. <i>422.2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cerebral Hemorrhage &amp; Left Hemiplegic</i> DUE TO <i>Emphysema &amp; Insufficiency</i>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>May 1, 1950</i> to <i>July 12, 1950</i> , that I last saw the deceased alive on <i>July 11, 1950</i> , and that death occurred at <i>5:01 a.m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Andrew Wozniak</i>		23B. ADDRESS <i>3029 Eastern Ave.</i>		23C. DATE SIGNED <i>7/14/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-15-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Stanislaus</i>	
24D. LOCATION (City, town, or county) (State) <i>Dundalk Ave. Ind.</i>		24E. FUNERAL DIRECTOR <i>John J. Duda, Inc.</i>		24F. ADDRESS <i>5829 Hudson St (24)</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>		REGISTRAR'S SIGNATURE <i>Walter J. Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS <i>John J. Duda, Inc. 5829 Hudson St (24)</i>	



525  
6174BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6174  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN RANKIN

2. DATE  
OF  
DEATH

7/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONUniversity Shops -  
40 yrs

C. Length of stay in Baltimore

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

Yrs.  
Mos.  
Days4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

19-03

D. STREET ADDRESS (If rural, give location)

1307 W. LOMBARD ST

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Kitchen Hand

10B. KIND OF BUSINESS OR  
INDUSTRY

Miller Bros.

13. FATHER'S NAME

ZITKO RANKIN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Charles J. Lloyd Lombard St

18.

610 X  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A)

UREMIA

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

URINARY OBSTRUCTION

DUE TO

BPH

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/50, 1950, to 7/13, 1950, that I last saw the  
deceased alive on 7/12, 1950 and that death occurred at 7:30 Pm., from the causes and on the date stated above.

23A. SIGNATURE

Leonard Bachman M. D.

23B. ADDRESS

University Hosp

23C. DATE SIGNED

7-13-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7/17/50

24C. NAME OF CEMETERY OR CREMATORY

St Pauls Cem

24D. LOCATION (City, town, or county)

Laver Lane

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

John J. Brown 901 Hollis St

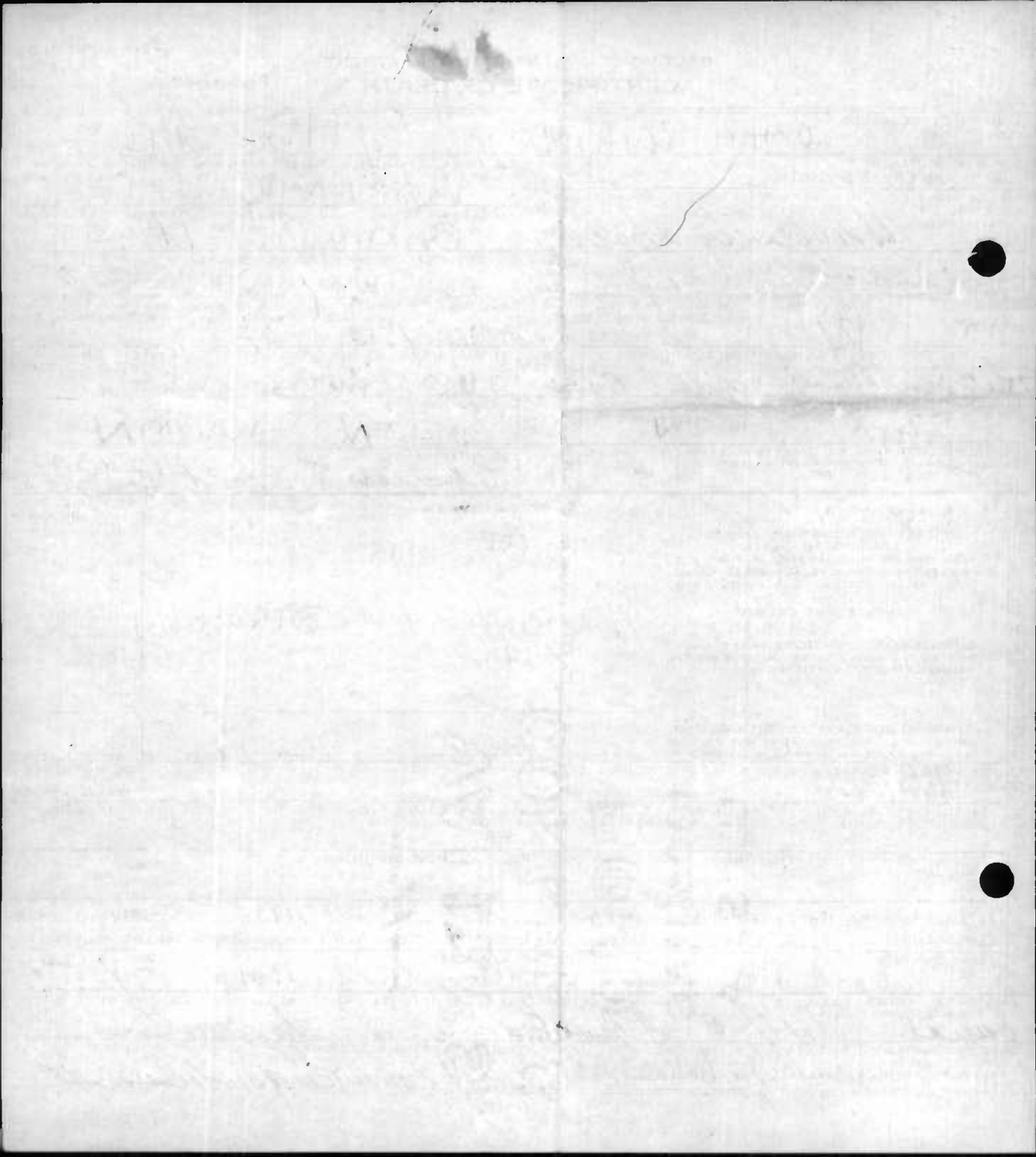
VS 150

7206M

175

137a

MEDICAL CERTIFICATION



326 50 6175		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50. 6175 Registered No.	
BIRTH NO.				2. DATE OF DEATH July 13, 1950	
1. NAME OF DECEASED (Type or Print) <b>MARCUS F. RITGER, SR.</b>				2. DATE OF DEATH July 13, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>9-01</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>637 Dumbarton Ave.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <b>637 Dumbarton Ave.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>JAN 16 1890</b>	9. AGE (In years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reporter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Frank Ritger</b>				12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service) <b>no</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Purzer</b>	
16. SOCIAL SECURITY NO. <b>213-03-2180</b>				17. INFORMANT ADDRESS <b>Mrs. Rosina C. Ritger - 637 Dumbarton Ave</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Nephroclerosis &amp; Kidney disease</b> DUE TO <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Glaucoma &amp; Failure - Glaucoma</b> DUE TO <b>Coeliac &amp; Volvulations</b>				INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov 7, 1949</b> to <b>July 13, 1950</b> , that I last saw the deceased alive on <b>July 12, 1950</b> , and that death occurred at <b>Home</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Donald W. Mintzes</b>		23B. ADDRESS <b>3009 Freeween Ave Balto</b>		23C. DATE SIGNED <b>7/13/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/15/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR		24F. REGISTRAR'S SIGNATURE <b>John Williams, M.D.</b>	
24G. FUNERAL DIRECTOR <b>Wm. J. Tickers &amp; Sons - Balto</b>		24H. ADDRESS <b>131a</b>			
JUL 14 1950 036826 76 131a					

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

IN SENATE  
January 18, 1910  
REPORT OF THE  
COMMISSIONER OF HEALTH  
FOR THE YEAR 1909  
ALBANY: J.B. LIPPINCOTT & CO. 1910

ALBANY: J.B. LIPPINCOTT & CO. 1910

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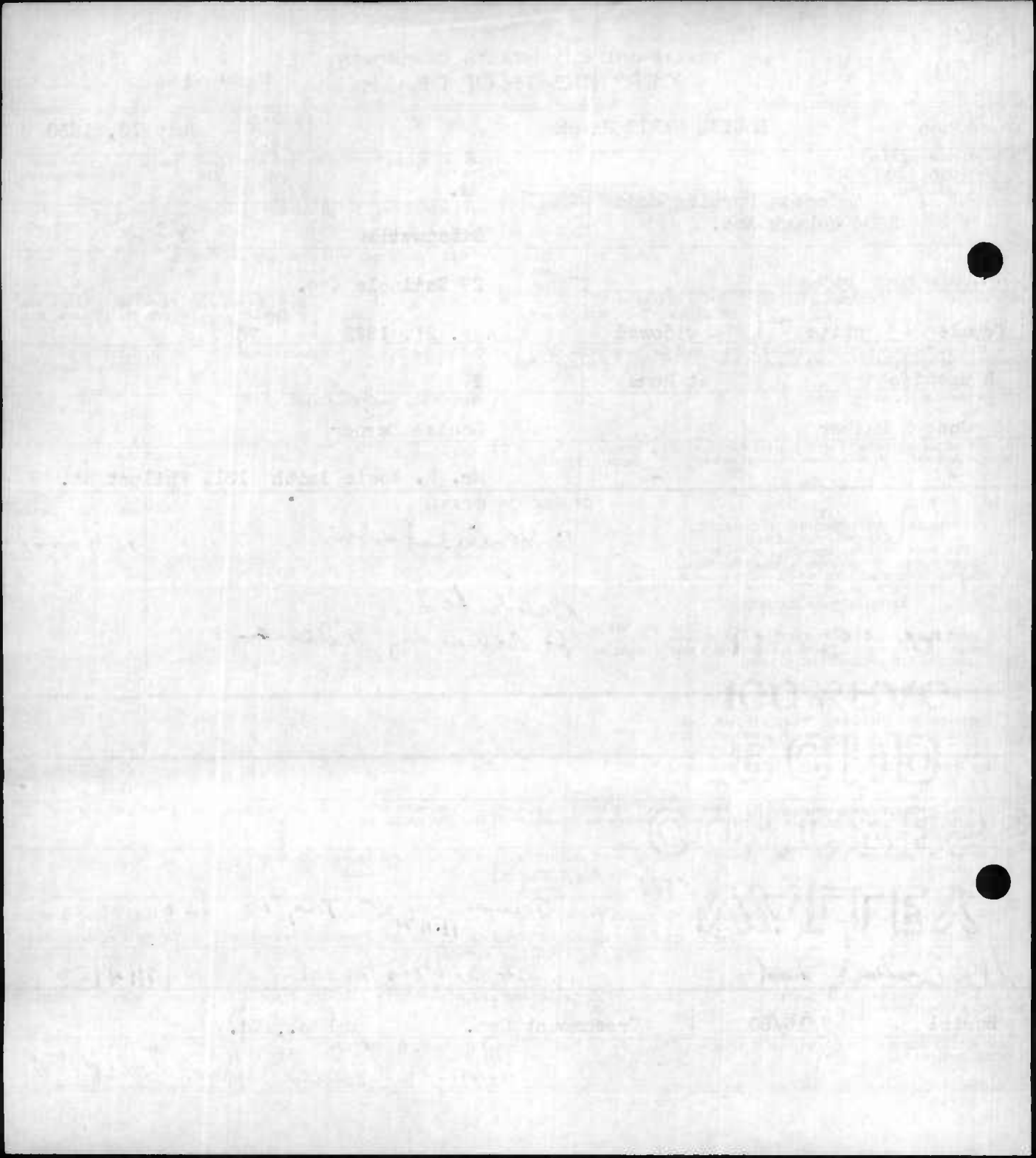


100  
50 6176

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 6176  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		LOUISE MARIE RABBE		2. DATE OF DEATH July 13, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
B. FULL NAME OF HOSPITAL OR INSTITUTION Anderson Nursing Home 3604 Mohawk Ave.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville			
C. Length of stay in Baltimore 27 Days				D. STREET ADDRESS (If rural, give location) 27 Seminole Ave. 5300			
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Aug. 21, 1873	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		9. AGE (in years last birthday) 76		11. BIRTHPLACE (State or foreign country) ?	
13. FATHER'S NAME Joseph Raiber				12. CITIZEN OF WHAT COUNTRY? ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -				16. SOCIAL SECURITY NO. -		14. MOTHER'S MAIDEN NAME Louise Berner	
17. INFORMANT Mr. F. Bowie Smith				ADDRESS 1311 Philpot St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260 X I arteriosclerosis				CAUSE OF DEATH (A) DUE TO arteriosclerosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(B) DUE TO Diabetes Pulmonary Edema			
19A. DATE OF OPERATION 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1925 to Aug 13, 1950, that I last saw the deceased alive on July 12, 1950, and that death occurred at 11:15 A. M., from the causes and on the date stated above.							
23A. SIGNATURE W. L. Fisher				23B. ADDRESS 20 S. Preston St. M. D.		23C. DATE SIGNED 7/14/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/15/50		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		24D. LOCATION (City, town, or county) (State) Bal to., Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Wm. J. Fisher		25. FUNERAL DIRECTOR Wm. J. Fisher		ADDRESS Baltimore, Md.	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6177  
Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>GETAL LEAH TSATSKIS</b>		2. DATE OF DEATH <b>7-13-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1619 No Pulaski St</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-02</b>			
C. Length of stay in Baltimore <b>30</b> Yrs. <u>    </u> Mos. <u>    </u> Days <u>    </u>		D. STREET ADDRESS (If rural, give location) <b>1619 No Pulaski St</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>7-8</b>	9. AGE (In years last birthday) <b>78</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Karl</b>		14. MOTHER'S MAIDEN NAME <b>Esther</b>		12. CITIZEN OF WHAT COUNTRY? _____	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Sersh Tsatskis</b> ADDRESS <b>Same</b>	

18. <b>442x</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH (A) <b>Chr. Myocarditis 10 yrs</b> DUE TO _____
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) <b>Cardio-Renal Vascular disease 10 yrs</b> DUE TO _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) _____

19A. DATE OF OPERATION <b>no</b>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>June 1949</b> to <b>July 13 1950</b> that I last saw the deceased alive on <b>July 13 1950</b> and that death occurred at <b>4:15 p.m.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Benjamin Samuels</b> M. D.		23B. ADDRESS <b>2138 W. North Ave</b>		23C. DATE SIGNED <b>7/14/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-14-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Beth Tefel</b>	24D. LOCATION (City, town, or county) (State) <b>Balti md</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Joseph Lewis</b> ADDRESS <b>me</b>	

Baruch  
7128 W North Ave  
10741

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6178  
Registered No. \_\_\_\_\_

160  
0 6178  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MORRIS SHAPIRO</b>			2. DATE OF DEATH <b>7-13-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Amor</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-088</b>		
C. Length of stay in Baltimore <b>55</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>2214 Roslyn Ave</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>7-13</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Grocer</b>	11. BIRTHPLACE (State or foreign country) <b>Ruth</b>		
13. FATHER'S NAME <b>Daved</b>		12. CITIZEN OF _____ COUNTRY? <b>U.S.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____			
17. INFORMANT <b>Joseph Krueger 2214 Roslyn Ave</b>		18. MOTHER'S MAIDEN NAME <b>Esther Stanley &amp; Dunderberg M.D.</b>			

18. <b>E903.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Subdural hematoma, left</b> DUE TO <b>Subdural hygroma, right</b> DUE TO <b>Skull fracture, occipital.</b> <b>Pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>Accident</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Walking down Roslyn Ave. towards his home</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 1, 1950 P.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell backward to pavement striking head</b>	
22. I hereby certify that I attended the deceased from <b>7-6</b> , 19 <b>50</b> , to <b>7-13</b> , 19 <b>50</b> ; that I last saw the deceased alive on <b>7-13</b> , 19 <b>50</b> , and that death occurred at <b>7:25</b> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>William</b>		23B. ADDRESS <b>Anni Hospital M. D.</b>		23C. DATE SIGNED <b>7-13-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-14-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Anni Israel</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>Jack Lewis Inc 2100 Cent Ave</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>		REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>			





163  
50 6179BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6179

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES F. ROBERTS</b>		2. DATE OF DEATH <b>July 13, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1404 Towson Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 24-01</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1404 Towson Street</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 6, 1920</b>
9. AGE (In years last birthday) <b>30</b>		10. Under 1 Year Months: Days: Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevadore (retired)</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Martin A. Roberts</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. O'Brien</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>2-6-42-15-44 217-09-6994</b>	
17. INFORMANT <b>Mary E. Roberts</b>		ADDRESS <b>1404 Towson Street</b>	

18. <b>411X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic heart disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an <u>autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>Stanley A. Durlacher</i>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 14, 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	24B. DATE <b>7/17/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balto National</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>	REGISTRAR'S SIGNATURE <i>William M. Ruff</i>	25. FUNERAL DIRECTOR <i>R. M. Walters</i>	

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

quincy if rheumatism

fever was <sup>not</sup> present, &

not action at time of death

Dr Foster's office  
filled in "not", "not",

above 18-7-49

Ed

620

50 6180-

CERTIFICATE CORRECTED 8-2-50

50 6180

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Raphael Scherza

2. DATE  
OF  
DEATH

July 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baltimore City

4. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give township)

Baltimore City, 3-01

D. STREET ADDRESS (If rural, give location)

1429 Bank St.

c. Length of stay in Baltimore

25 yrs.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Jan. 23, 1887

9. AGE (in years last birthday)

62 63

10 Under 1 Year

5 1

11 Under 24 Hours

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10B. KIND OF BUSINESS OR INDUSTRY

Packing House

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

Italy

13. FATHER'S NAME

Cosmo Scherza

14. MOTHER'S MAIDEN NAME

Lucy Lanza

15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219-01-9656

17. INFORMANT

ADDRESS

Theresa Scherza 1429 Bank St.

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast

DUE TO

with General metastasis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/12, 1948 to 7/12, 1950 that I last saw the deceased alive on 7/12, 1950, and that death occurred at 7 P. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

A. H. Hornstein

M. D.

204 E. Biddle St

7/14/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 15, 1950

Holy Redeemer

Belair Road

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 14 1950

Wendell J. Dippel

3125 Highland Ave

VS 150

97042

50

MEDICAL CERTIFICATION



660  
50 6181BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6181  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Grier

2. DATE  
OF  
DEATH

JUL 12 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

5. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

19-02

D. STREET ADDRESS (If rural, give location)

126 N. Mount St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

5-9-90

9. AGE (in years  
last birthday)

60

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Matthews, Co. N. C.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Epan Grier

14. MOTHER'S MAIDEN NAME

Mattie Grier.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 450.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ? arterial gangrene lower limbs

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ? arteriosclerosis d

DUE TO

(C) ? saddle embolus

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.Prostatic enlargement & urinary  
obstruction and an episode of  
hemiparesis

19A. DATE OF OPERATION

15 June 50

19B. MAJOR FINDINGS OF OPERATION

Dry gangrene lower limbs

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-6-1950 to 7-12-1950 that I last saw the  
deceased alive on 7-12-1950 and that death occurred at 1:40 a. m., from the causes and on the date stated above.

23A. SIGNATURE

H. Page Harris

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7/12/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

July 15, 1950

24C. NAME OF CEMETERY OR CREMATORY

Mt Calvary

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS 322 N

Mrs Katie R Williams Schroeder

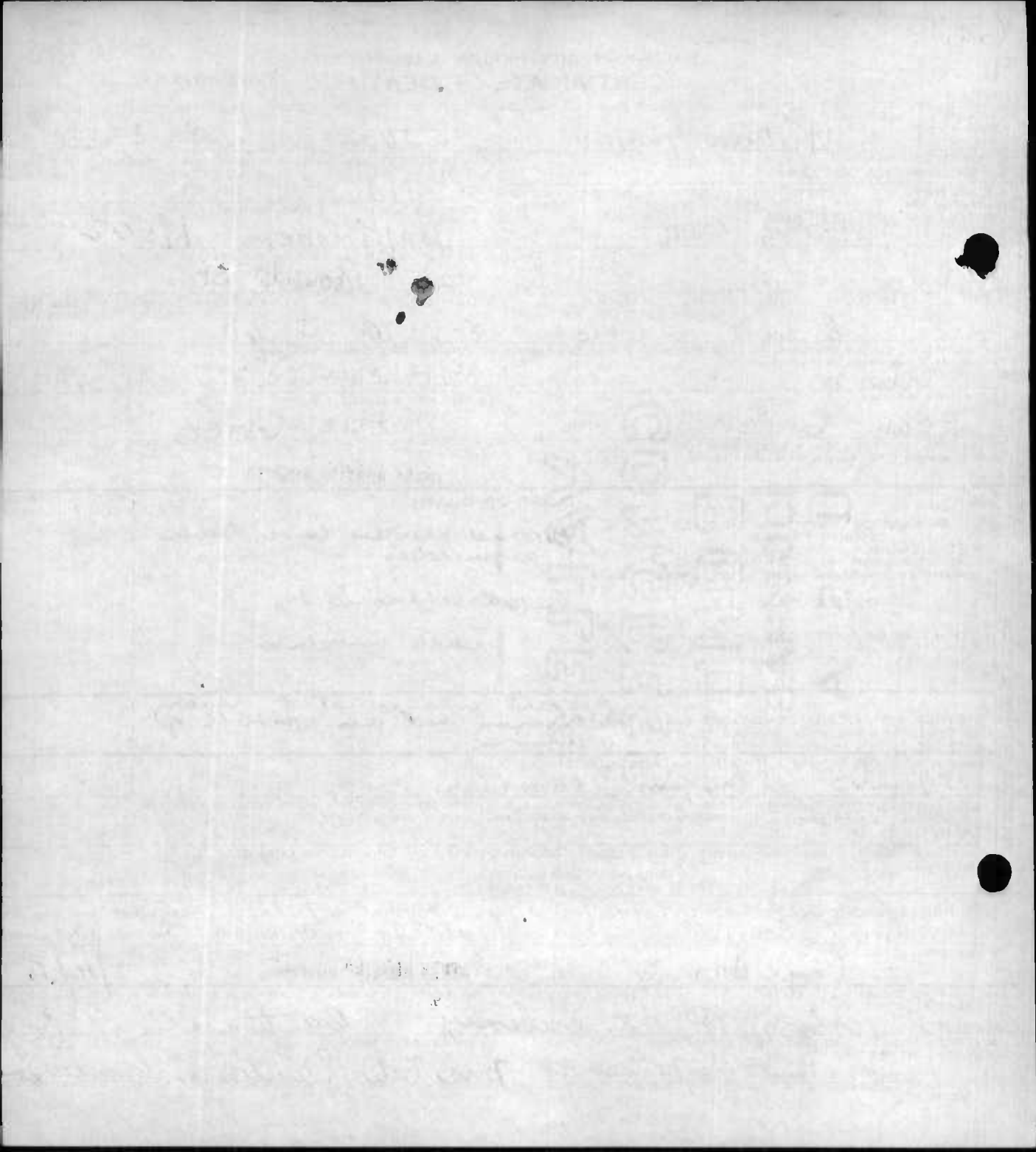
JUL 14 1950

VS 150

97099

98

MEDICAL CERTIFICATION

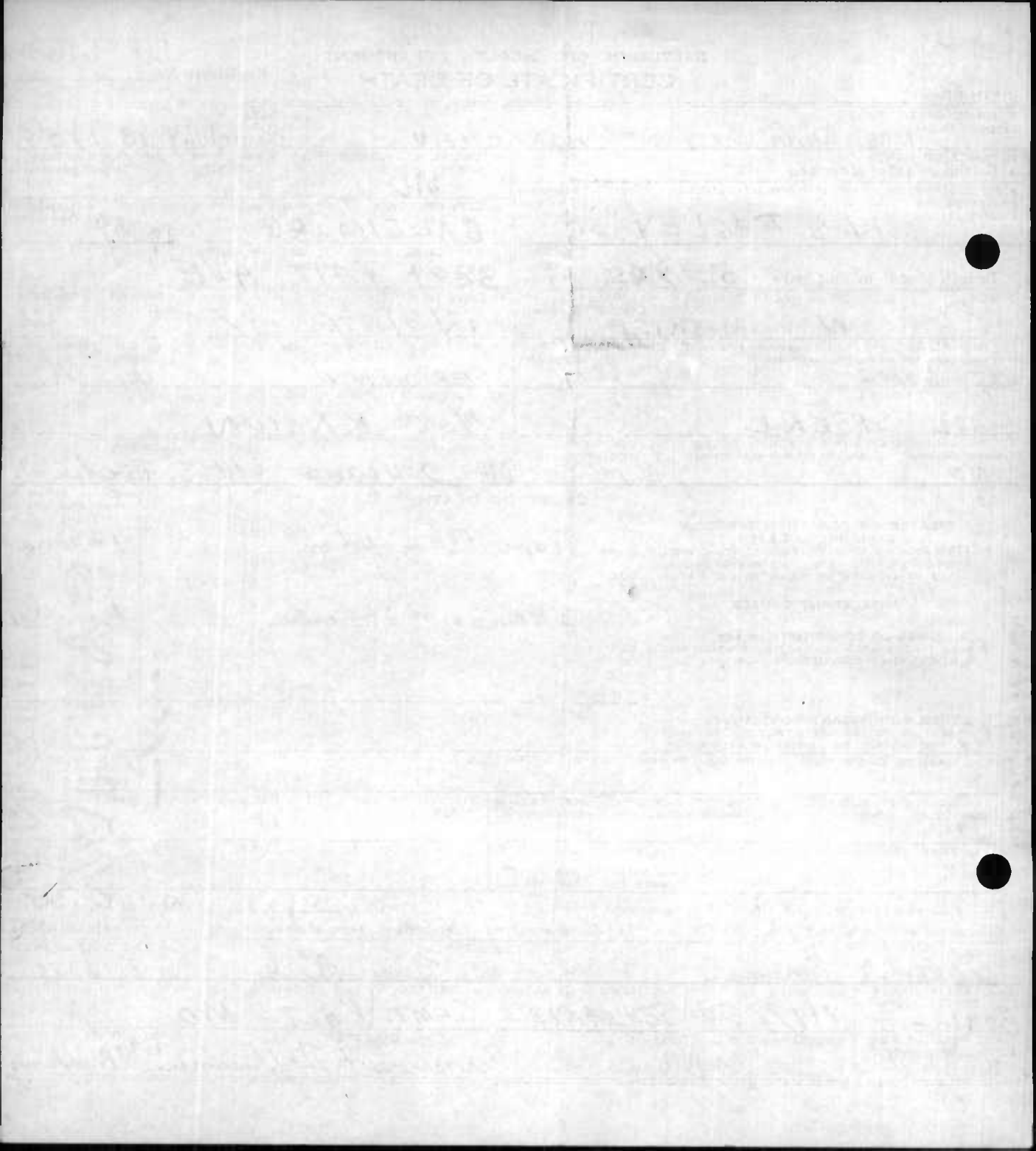




525  
6182LANKENAU  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6182  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MRS. ANNA MARGARET LANKENAU</b>		2. DATE OF DEATH <b>JULY 13 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>614 S. FAGLEY ST.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 26-09</b>			
c. Length of stay in Baltimore <b>50 YRS.</b>		D. STREET ADDRESS (If rural, give location) <b>3804 FAIT AVE</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>12/6/1876</b>	9. AGE (In years last birthday) <b>73</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>CARL SPOERL</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>MRS. DOULONG 614 S. Fagley ST.</b>	
18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Toxic Absorption</b> DUE TO (B) <b>Carcinoma of Stomach</b> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>19 Hours</b> <b>6 months</b>					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., io or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Feb 10, 1950</b> , to <b>July 13, 1950</b> , that I last saw the deceased alive on <b>July 12, 1950</b> , and that death occurred at <b>6:30 A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Michael J. Dausch</b>		23B. ADDRESS <b>4636 Belair Road</b>		23C. DATE SIGNED <b>7/13/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/17/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>SCHWARTZ'S CEMT. BALTO. MD.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	
24G. FUNERAL DIRECTOR <b>Clarence F. Hoffmann</b>		24H. ADDRESS <b>1639 Broadway</b>		24I. VS 150	

46B



-236  
0 6183BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6183  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK A. WAXTER

2. DATE  
OF  
DEATH

JULY 13, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION UNION MEMORIAL HOSPITAL4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

(17)

D. STREET ADDRESS (If rural, give location)

ALTAMONT HOTEL

c. Length of stay in Baltimore

73

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
WIDOWED10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

RETIRED ENTREPRENEUR

10B. KIND OF BUSINESS OR  
SUSQUEHANNA INDUSTRY  
ICE CO.

13. FATHER'S NAME

WILLIAM P. WAXTER (D)

8. DATE OF BIRTH

MARCH 17, 1877

9. AGE (In years  
last birthday)

73

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

MARGARET SPRUCEBANK (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

MRS. LESLIE HERBERT

ADDRESS  
LOMBARDY APTS  
220 STONEY RUN LANE

18. 443X I

CAUSE OF DEATH

BALTO. 70

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE

DUE TO

1 MONTH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE

DUE TO

(C) ARTERIOSCLEROSIS, GENERALIZED

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 7, 1950, to JULY 13, 1950, that I last saw the  
deceased alive on JULY 13, 1950, and that death occurred at 11:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Wallace L. Butterfield

23B. ADDRESS

Union Memorial Hospital

23C. DATE SIGNED

July 14, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-15-50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore

24D. LOCATION (City, town, or county) (State)

Balto, Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

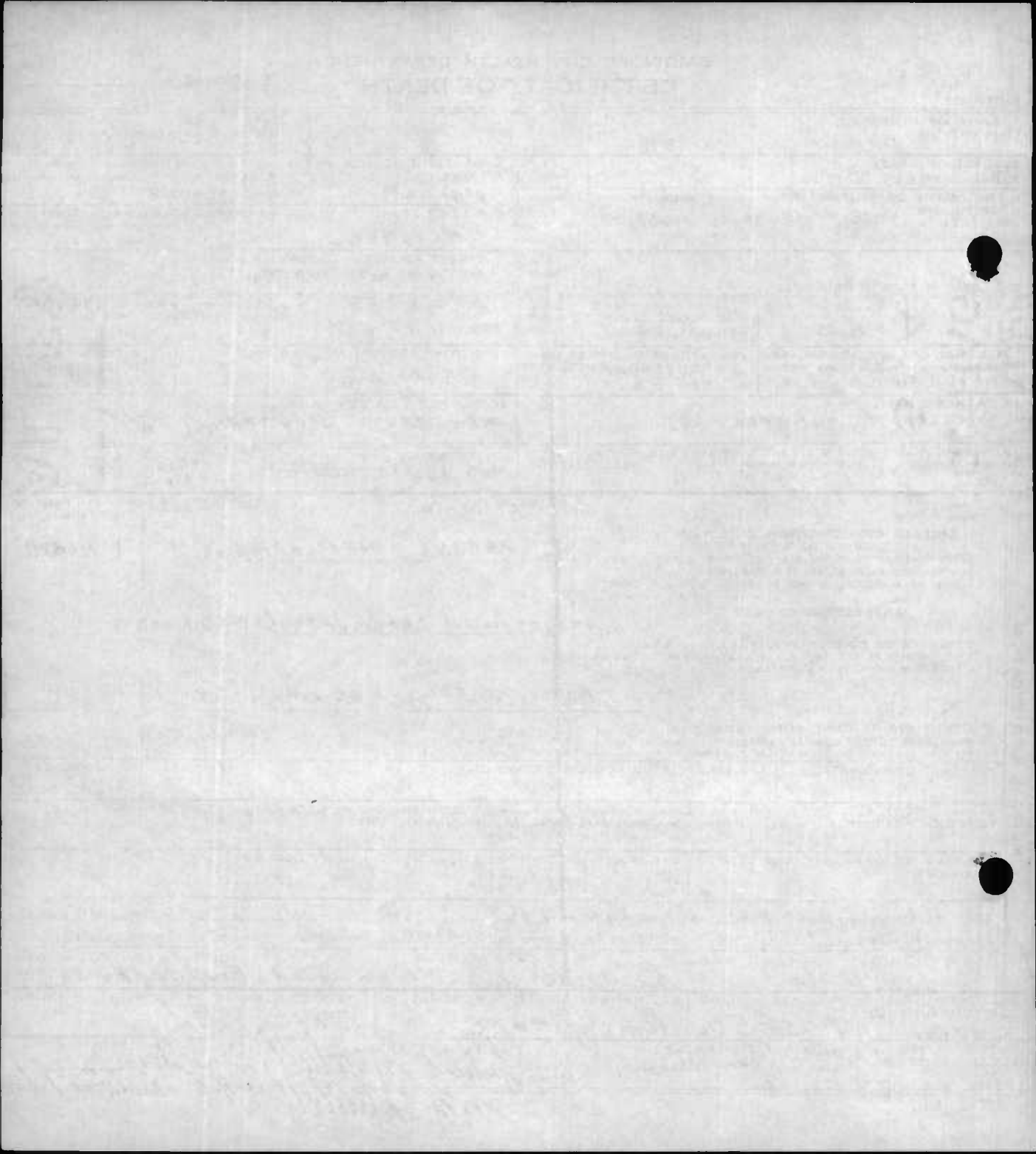
John Mitchell &amp; Sons, Inc.

JUL 14 1950

VS 150

2906T Mrs Mitchell

93D



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 6184

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WYNIE COLEMAN FRANKLIN</b>				2. DATE OF DEATH <b>July 13, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Georgia</b> B. COUNTY <b>V-09</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Swainsboro</b>	
C. Length of stay in Baltimore <b>1</b> Yrs. <b>7</b> Mos. <b>Days</b>				D. STREET ADDRESS (If rural, give location)	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>11-26-90</b>	9. AGE (In years last birthday) <b>59</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (Housewife)</b>				11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Coleman</b>				14. MOTHER'S MAIDEN NAME <b>Fannie Lake</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.	
17. INFORMANT <b>J. H. H. Records</b>				ADDRESS	

<p>18. <b>F979X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Skull fracture with contusion of brain and cerebral hemorrhage</b></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Psychotic depressive reaction with suicidal intendency</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p>
--	---

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Fayette and Wolfe Sts.</b>
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>July 13, 1950 11:40 A.M.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Jumped in front of streetcar</b>
<p>22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/>, accident <input type="checkbox"/>, suicide <input checked="" type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.</p>		
23A. SIGNATURE <b>R. S. Fisher</b>	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <b>July 13, 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	24B. DATE <b>7/17/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>City Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Swainsboro, Ga.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 14 1950</b>	REGISTRAR'S SIGNATURE <b>William Williams</b>	25. FUNERAL DIRECTOR <b>John O Mitchell + sons</b> <b>1900 Putnam Pl</b>	

MEDICAL CERTIFICATION





142

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6185

BIRTH NO. 6185

1. NAME OF DECEASED  
(Type or Print)

Ables Mrs. Anna

2. DATE  
OF  
DEATH

14 July 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Church Home Hospital

C. Length of stay in Baltimore

1 month 5 days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,

WIDOWED, DIVORCED

WIDOWED

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE: MARYLAND. COUNTY: BALTIMORE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

150 N. Milton Ave.

6-02

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ARKANSAS

12. CITIZEN OF WHAT COUNTRY?

American United States

13. FATHER'S NAME

DREHER John

14. MOTHER'S MAIDEN NAME

Anna PAIT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

DR HARRY TANKIN

ADDRESS: 150 N. M. H. Ave. Baltimore

18. 154X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno Carcinoma of the Rectum

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

4 mo.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease

19A. DATE OF OPERATION

29 June 1950

19B. MAJOR FINDINGS OF OPERATION

Inoperable Ca of Rectum

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 July, 1950, to 14 July, 1950, that I last saw the deceased alive on 14 July, 1950, and that death occurred at 5:30 A. M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

Church Home Hospital

14 July 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/15/50

24C. NAME OF CEMETERY OR CREMATORY

Moreland Mem. Ch.

24D. LOCATION (City, town, or county)

Baltimore

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

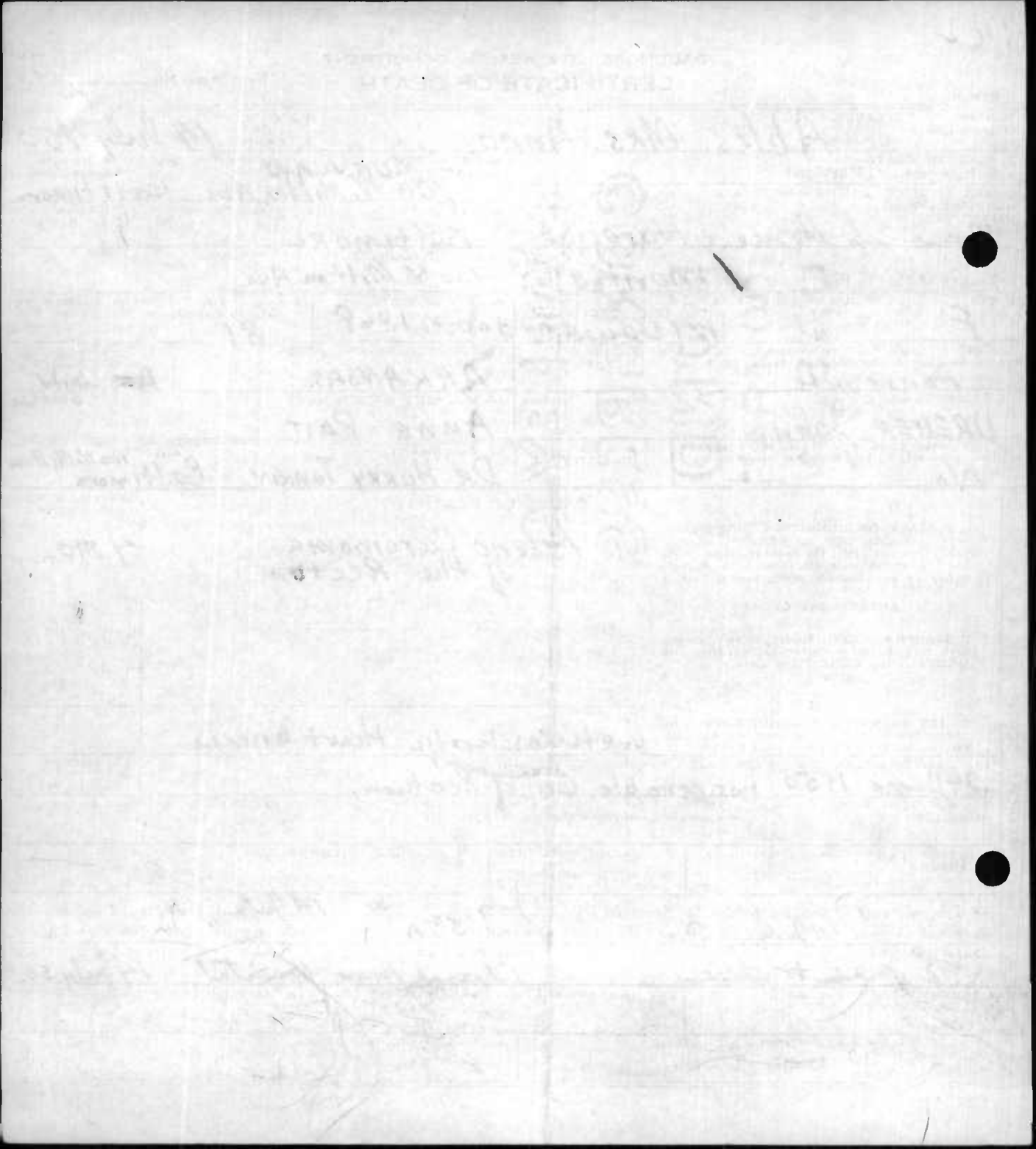
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Philip Surgery Sons

ADDRESS

2324 Orleans St



-400  
50 6186BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6186

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DAISY EDWARDS HALL

2. DATE  
OF  
DEATH

JULY 12, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

1311 EAST FEDERAL STREET

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE

MARYLAND

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
BALTIMORE

D. STREET ADDRESS (If rural, give location)

1311 EAST FEDERAL STREET

5. SEX

FEMALE

6. COLOR OR RACE

NEGRO

7. SINGLE, MARRIED,

WIDOWER, DIVORCED (Specify)

MARRIED

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

MARCH 22, 1891

9. AGE (In years;  
last birthday)

59

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

-----

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

EMMA HOLMES

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

-----

17. INFORMANT

ADDRESS

CHAS. HALL - 1311 E. FEDERAL STREET

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

Hypertensive Cardiovascular Disease

DUE TO

10 yrs

II

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, Irregularly Irregularly Irregularly 10 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from June 30, 1950 to July 12, 1950, that I last saw the deceased alive on July 12, 1950, and that death occurred at 10:15 P. M., from the causes and on the date stated above.

23A. SIGNATURE

M. O.

23B. ADDRESS

1429 E. MONUMENT STREET

23C. DATE SIGNED

7/13/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

7-15-50

24C. NAME OF CEMETERY OR CREMATORY

MOUNT AUBURN CEMETERY

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

DATE RECEIVED BY REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

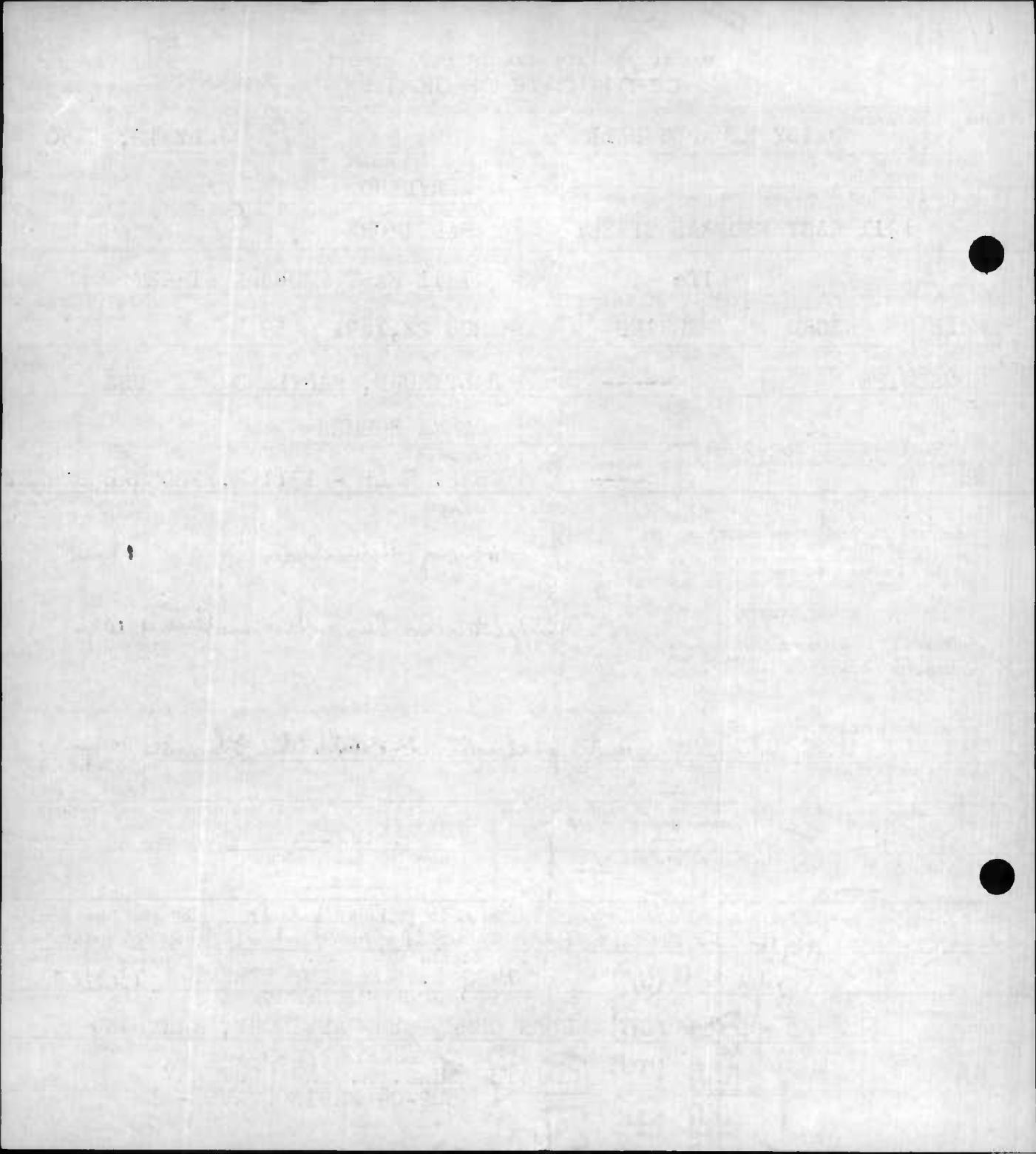
ADDRESS

THE CHAS. R. LAW MORTUARY

802-04 MADISON AVE - 1

VS 150

937



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6187  
Registered No. \_\_\_\_\_

650  
6187  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Arthur Durham</u>			2. DATE OF DEATH <u>7-11-50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>City</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>25-02A</u>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>455 Round View Rd.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore Cherry Hill</u>		
C. Length of stay in Baltimore <u>2 1/2 yrs.</u>			D. STREET ADDRESS (If rural, give location) <u>455 Round View Road.</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Feb. 8, 1894</u>	9. AGE (In years, last birthday) <u>56 yrs.</u>	10. Under 1 Year Months: <u>5</u> Days: <u>3</u> Hours: <u>-</u> Min: <u>-</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		
11. BIRTHPLACE (State or foreign country) <u>Hillsboro, S.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Warne Durham</u>			14. MOTHER'S MAIDEN NAME <u>Rhett Durham</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-06-0022</u>		
17. INFORMANT <u>Anna Durham</u>			ADDRESS <u>✓</u>		

<p>18. <u>480. X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH (A) <u>Pneumonia</u> DUE TO</p> <p>ANTECEDENT CAUSES (B) <u>Grippe</u> DUE TO</p> <p>(C) <u>Arteriosclerosis</u></p>	<p>INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u></p>

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>MAY 25</u> , 19 <u>50</u> , to <u>July 11</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>50</u> , and that death occurred at <u>8:15 A.M.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Larry C. Luck</u>		23B. ADDRESS <u>427 Swale ave</u>		23C. DATE SIGNED <u>7-11-50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		24B. DATE <u>15/7/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cathart Cr.</u>	
		24D. LOCATION (City, town, or county) <u>Cathart Cr.</u>		(State)	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 11 1950</u>		REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>Joseph C. Rynn</u>	
				ADDRESS <u>1200 McCall St.</u>	

100-111111

SECRET

CONFIDENTIAL

U.S. A.

100-111111



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6188  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ALICE CHASE</b>		2. DATE OF DEATH <b>7-12-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>PROVIDENT HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>16-01</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>PROVIDENT HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE, MD (12)</b>	
C. LENGTH OF STAY IN BALTIMORE <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1129 N. CAREY ST.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-13-1882</b>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		9B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	9. AGE (In years; last birthday) <b>68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>
13. FATHER'S NAME <b>STANLEY HAZLETON</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>W.</b>		14. MOTHER'S MAIDEN NAME <b>NANNIE GRIFFIN</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lucie Stansbury David Hill Co.</b>	

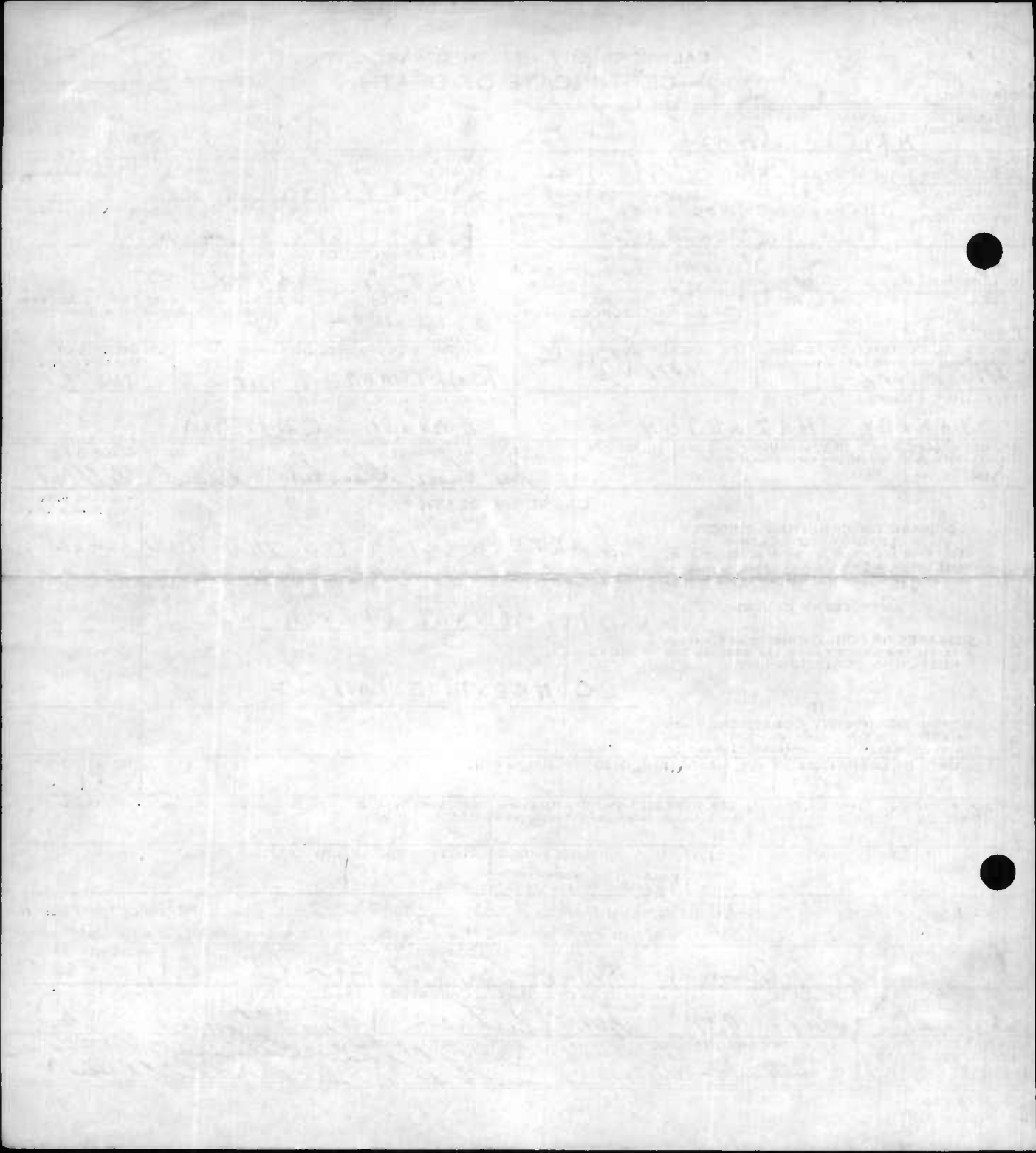
18. <b>470.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>ARTERIOSCLEROTIC HEART DIS.</b> DUE TO  <b>PULMONARY EDEMA</b> DUE TO  <b>CONGESTIVE FAILURE</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>APPROX. 7 yrs</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7-10, 1950, to 7-12, 1950, that I last saw the deceased alive on 7-12, 1950, and that death occurred at 6:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE <b>Salvador H. Pinney M.D.</b>		23B. ADDRESS <b>Provident Hospital</b>		23C. DATE SIGNED <b>7-12-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 15 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Wm. Auburn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>W. Halland Funeral Home</b>		ADDRESS <b>1600 David Hill Co.</b>	

DATE RECEIVED BY LOCAL REGISTRAR  
**JUL 14 1950**  
REGISTRAR'S SIGNATURE  
**Huntington Williams, M.D.**



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6189

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Byron Floyd Willis</i>			2. DATE OF DEATH <i>7-13-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balto</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Colonial Nursing Home</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Catonsville 28</i>		
C. Length of stay in Baltimore <i>4</i> Yrs. <i>4</i> Mos. <i>4</i> Days			D. STREET ADDRESS (If rural, give location) <i>607 Rest Ave 5300</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>1-26-1889</i>	9. AGE (In years last birthday) <i>61</i>	10. Under 1 Year Months: <i>6</i> Days: <i>18</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none CLERK</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>none GROCERY</i>		
11. BIRTHPLACE (State or foreign country) <i>New York State</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>		
13. FATHER'S NAME <i>Byron Willis</i>			14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>?</i>		
17. INFORMANT <i>Walter Willis</i>			ADDRESS <i>607 Rest Ave Catonsville 28 md</i>		

18. <i>J-26 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <b>ASTHMATIC BRONCHITIS</b>	INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	<b>BRONCHIECTASIS.....</b>	<b>4 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION <i>0</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>No</i>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i>
21D. TIME (Month) (Day) (Year) (Hour) INJURY <i>No</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>No</i>

22. I hereby certify that I attended the deceased from *Feb, 26,* 19*47* to *July, 13,* 1950, that I last saw the deceased alive on *June, 10,* 1950 and that death occurred at *10:20 PM* from the causes and on the date stated above.

23A. SIGNATURE <i>A. Lloyd Johnson</i>	23B. ADDRESS <i>610 FREDERICK ROAD</i>	23C. DATE SIGNED <i>7/14/50</i>
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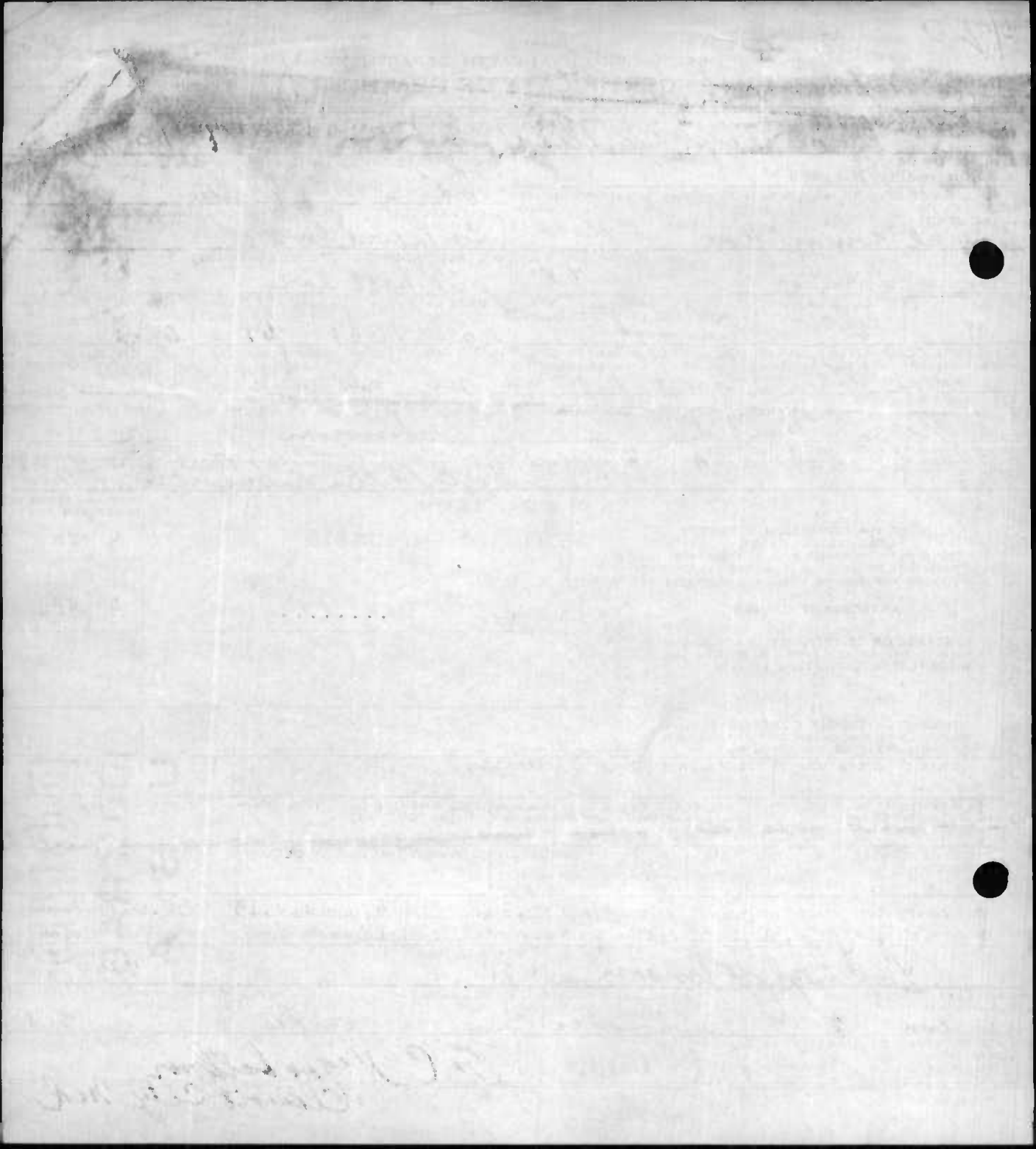
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	24B. DATE <i>8-15-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Landon Park</i>	24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>
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DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 14 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>F. C. Higginbotham</i>	ADDRESS <i>Ellicott City Md</i>
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4906A

106B

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

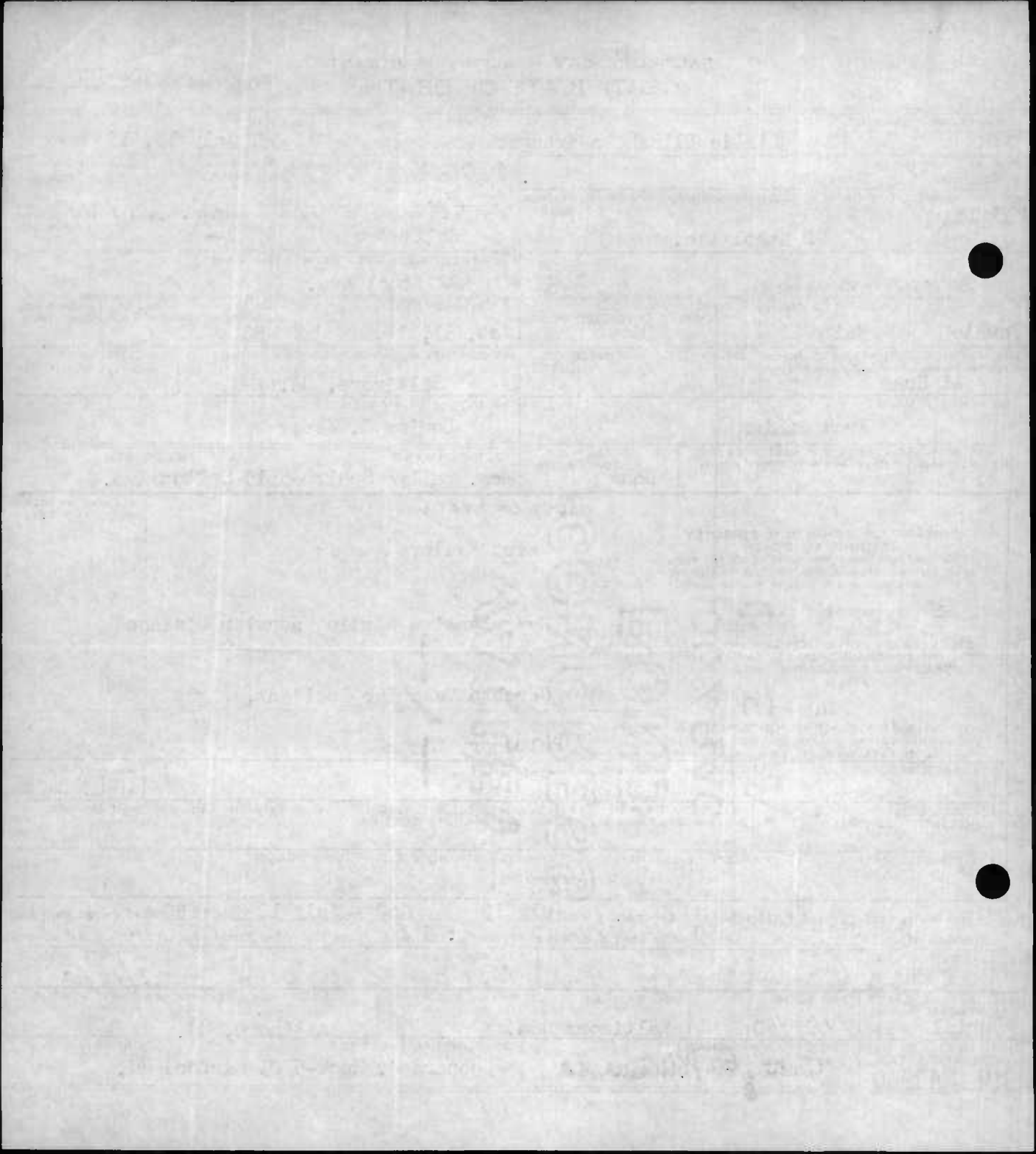
50 6190  
Registered No. 50-6190

620  
50 6190  
BIRTH NO.

1. NAME OF DECEASED (Type or Print)		Lillie Elisabeth Krausse		2. DATE OF DEATH July 13, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>22 Athol Ave.</u>		C. CITY OR TOWN (If outside corporate limits, name FULL and give township) <u>Baltimore</u>			
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>22 Athol Ave.</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 31, 1869</u>	9. AGE (in years last birthday) <u>80</u>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Fred Schirm</u>		14. MOTHER'S MAIDEN NAME <u>Louise J. Hesse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT ADDRESS <u>Mrs. Sallye Schirm-5515 Sefton Ave.</u>	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Heart Failure</u> DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Hypertensive Cardio Vascular Disease</u> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Cerebro Vascular Accident, right Pulmonary Edema</u>		

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>July 10</u> , 19 <u>50</u> , to <u>July 12</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>July 12</u> , 19 <u>50</u> , and that death occurred at <u>6:05 Am.</u> , from the causes and on the date stated above.				
23A. SIGNATURE <u>Cecil R. Ruff</u>		23B. ADDRESS <u>4617 Old Frederick Rd.</u>		23C. DATE SIGNED <u>7/18/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/15/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 14 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Williams, M.D.</u>	25. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck-5305 Harford Rd.</u>		





056 50 6191

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6191  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARY E. TURNER

2. DATE  
OF  
DEATH

7/12/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2001 N. Calvert St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

1898

9. AGE (in years  
last birthday)

52

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Michael Kavanaugh

14. MOTHER'S MAIDEN NAME

(?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Robt. Turner

ADDRESS

431 N. 24th St.

18. 196X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Carcinoma of Skull  
(Basal Cell)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Metastatic Carcinoma of Glands

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 30, 1950, to July 12, 1950, that I last saw the  
deceased alive on July 12, 1950, and that death occurred at 11 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7/15/50

St. Peters

City

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 14 1950

Christington Williams, M.D.

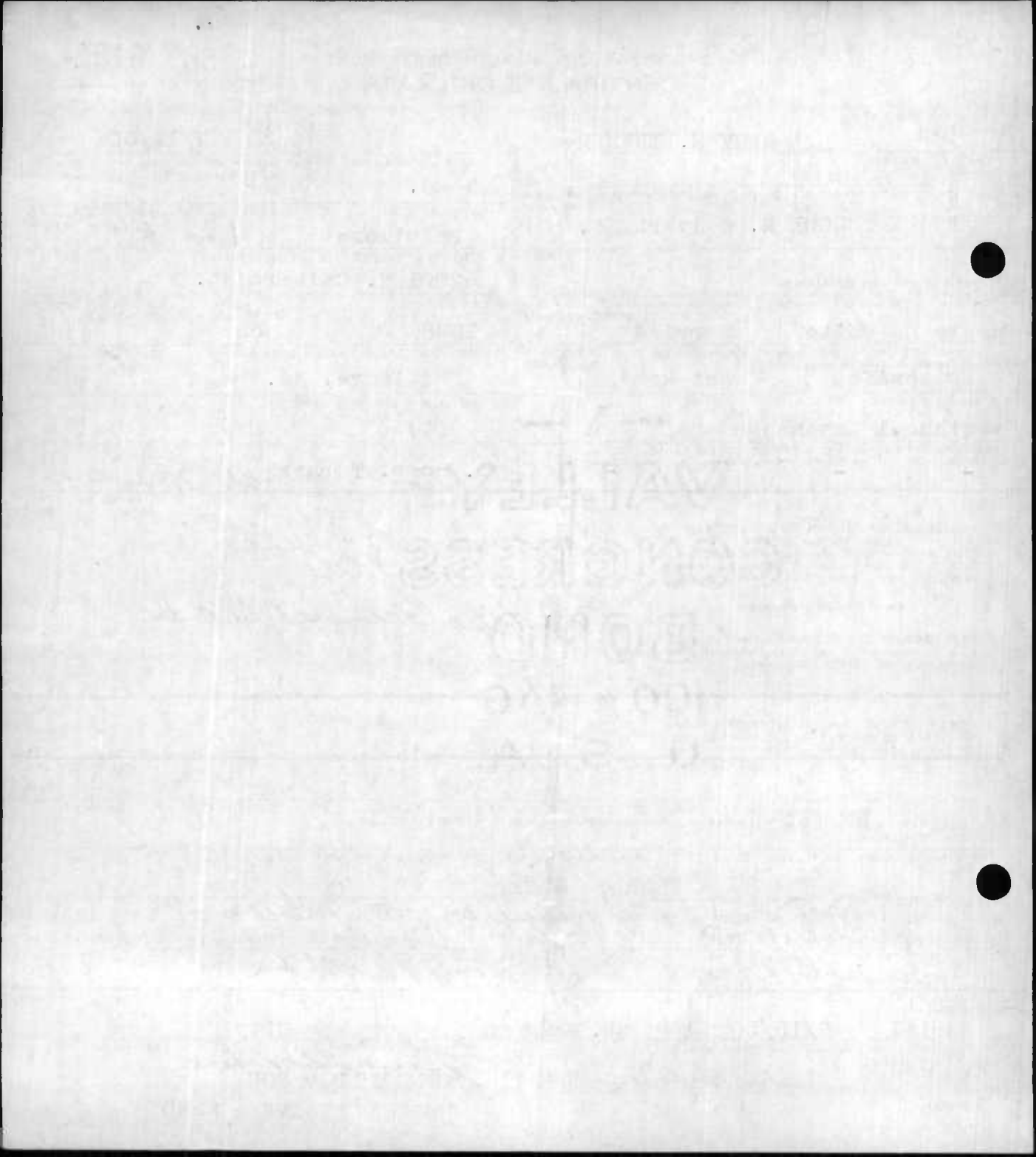
WIEDEBOLD &amp; SON

VS 150

GREENMOUNT AVE &amp; 22ND

550

MEDICAL CERTIFICATION



260  
50 6192BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6192  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN EDW. MCGUIRE

2. DATE  
OF  
DEATH

7/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

709 East 21st St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

709 East 21st St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

1880

9. AGE (in years  
last birthday)

70

11 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired-Foreman

10B. KIND OF BUSINESS OR  
INDUSTRY

Const.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John McGuire

14. MOTHER'S MAIDEN NAME

Catherine whalen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

709 E. 21st St.

Miss Catherine McGuire

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Myocardial Insufficiency 2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) DUE TO  
(C)Diabetes 2 yrs.  
Atherosclerosis (myeloid) 2 yrs.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1945 to July 13, 1950, that I last saw the  
deceased alive on 1950, and that death occurred at 12:03 PM, from the causes and on the date stated above.

23A. SIGNATURE

Thomas J. White M.O.

23B. ADDRESS

3809 Greenmount Ave

23C. DATE SIGNED

7/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/15/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

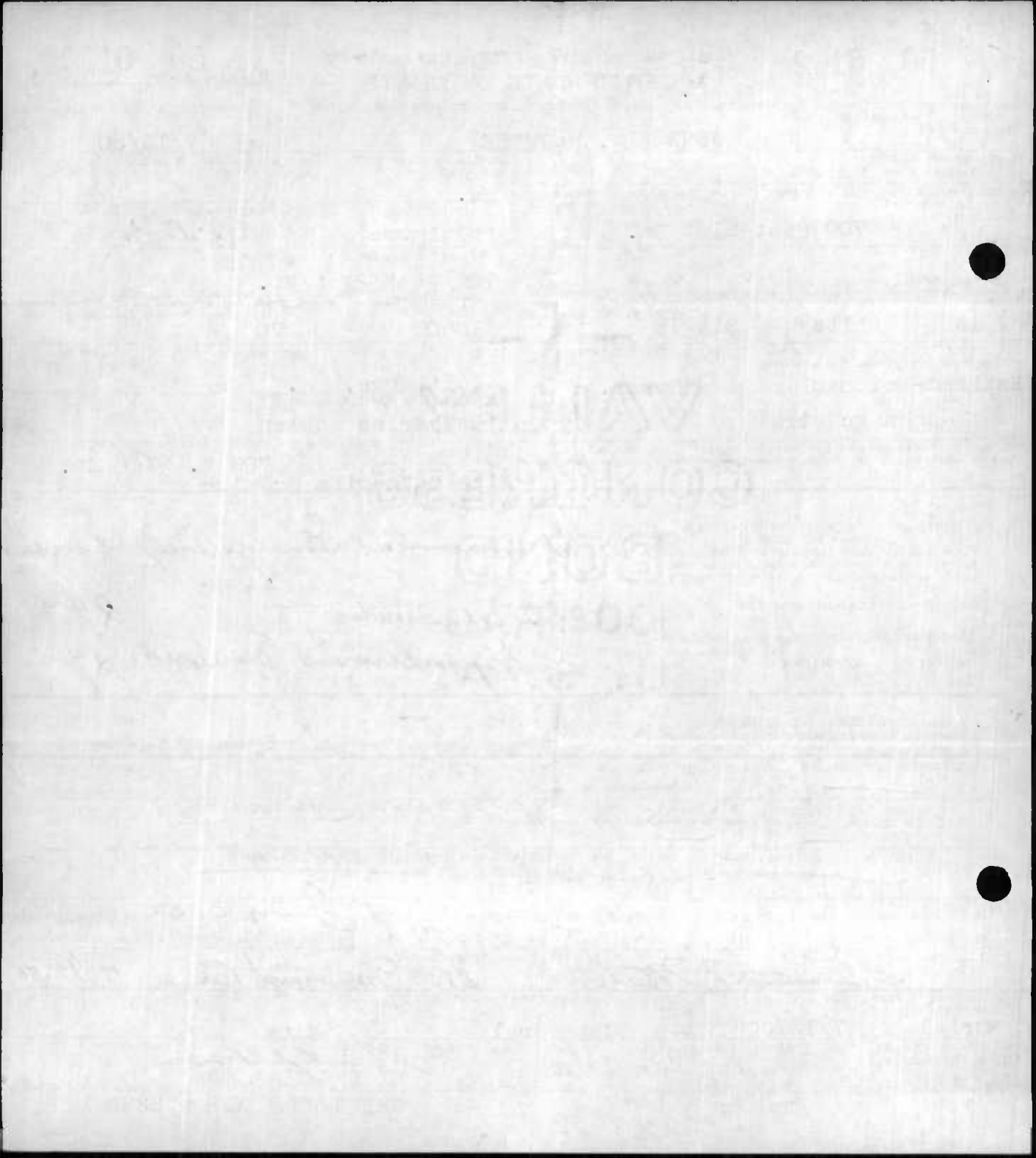
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VS 150

GREENMOUNT AVE &amp; 22ND

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BALTIMORE CITY HEALTH DEPARTMENT

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## CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

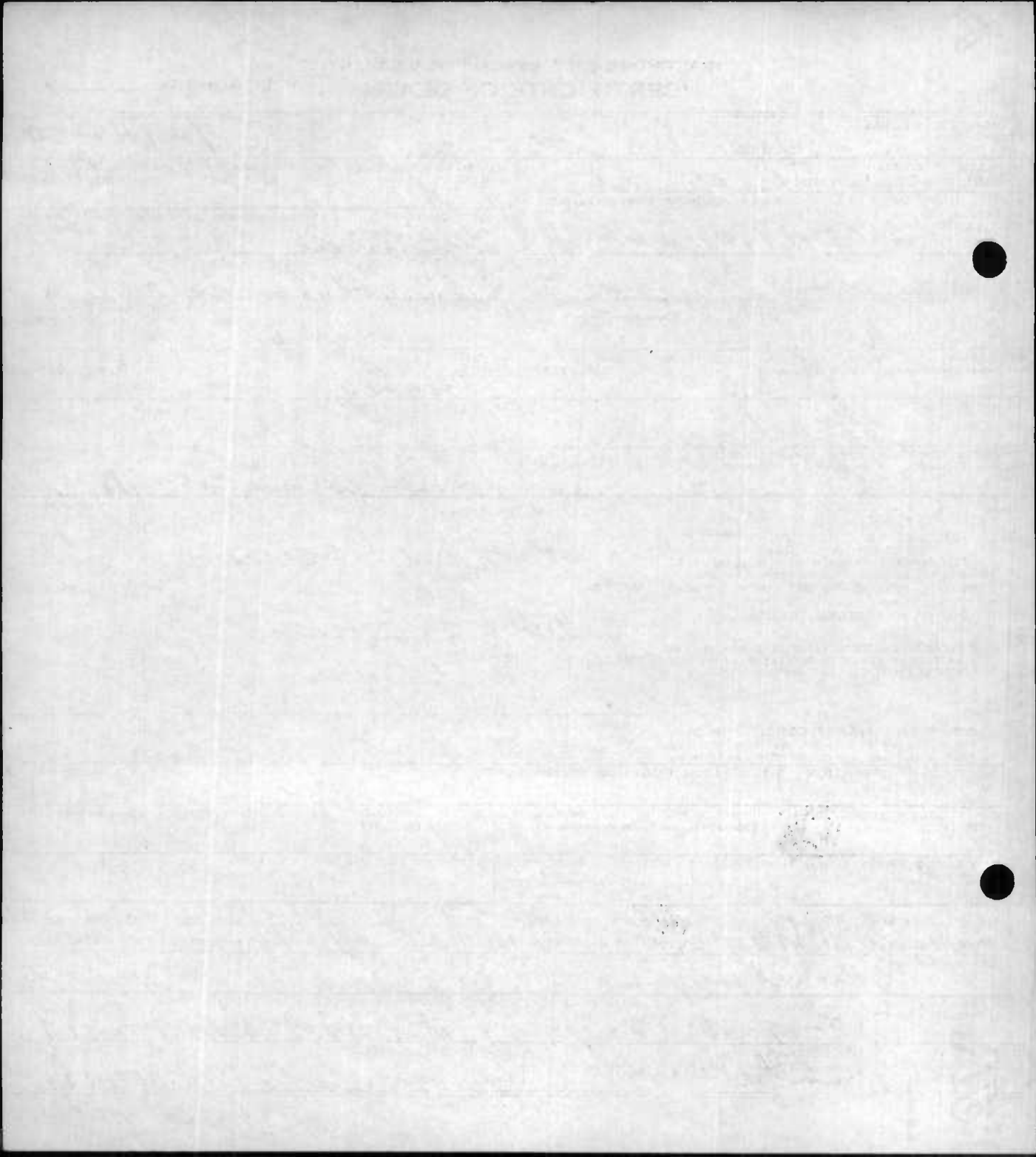
1. NAME OF DECEASED (Type or Print) <i>Argiro D. Coeonis</i>		2. DATE OF DEATH <i>7-14-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. md</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>2603 Allendale Rd.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <i>Baltimore 15-08A</i>	
c. Length of stay in Baltimore <i>10 years.</i> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <i>2603 Allendale Rd.</i>	
5. SEX <i>f.</i>	6. COLOR OR RACE <i>w.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years; last birthday) <i>67</i>
11. BIRTHPLACE (State or foreign country) <i>Trunkay</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Michael</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>James Coeonis</i>		ADDRESS <i>2603 Allendale</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1</i> <i>Coronary Occlusion</i>	CAUSE OF DEATH (A) <i>Coronary Occlusion</i> DUE TO (B) <i>Arteriosclerosis</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <i>18 hrs.</i> <i>7</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>July 3, 1950</i> to <i>July 13, 1950</i> , that I last saw the deceased alive on <i>July 13, 1950</i> , and that death occurred at <i>11:30 p.m.</i> , from the causes and on the date stated above.		
23A. SIGNATURE <i>E. Herbert Goldstone</i>	23B. ADDRESS <i>1810 Eutaw Pl.</i>	23C. DATE SIGNED <i>July 14</i>

24A. (BURIAL) CREMATION, REMOVAL (Specify)	24B. DATE <i>7-17-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Cemetery Mt. Olivet Brooklyn N.Y.</i>	24D. LOCATION (City, town or county) (State) <i>Brooklyn N.Y.</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 15 1950</i>	REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i>	25. FUNERAL DIRECTOR <i>Lambert Inc</i>	ADDRESS <i>440 E. North Ave</i>
VS 150 <i>94a Balto. md</i>			

MEDICAL CERTIFICATION





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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6194

Registered No.

1. NAME OF DECEASED (Type or Print) <b>Isabelle M. Ledley</b>		2. DATE OF DEATH <b>July 14, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2305 St. Paul Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 12-03</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2631 St. Paul Street</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Sept. 1876</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher - Ret.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>self</b>	9. AGE (In years last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Ledley</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <b>Mrs. Charles Gibbs, 2631 St. Paul Street</b>	

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic arteriosclerotic cardiovascular disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <b>Arteriosclerosis &amp; Senility</b> DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Passive Hepatitis</b> <b>Purpura Hemorrhagica</b>		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct 14, 1949</b> , to <b>July 14, 1950</b> , that I last saw the deceased alive on <b>July 12, 1950</b> and that death occurred at <b>8:45 Am.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H. V. Harbold</b>		23B. ADDRESS <b>4706 Harvard Road</b>		23C. DATE SIGNED <b>July 14, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/15/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>					

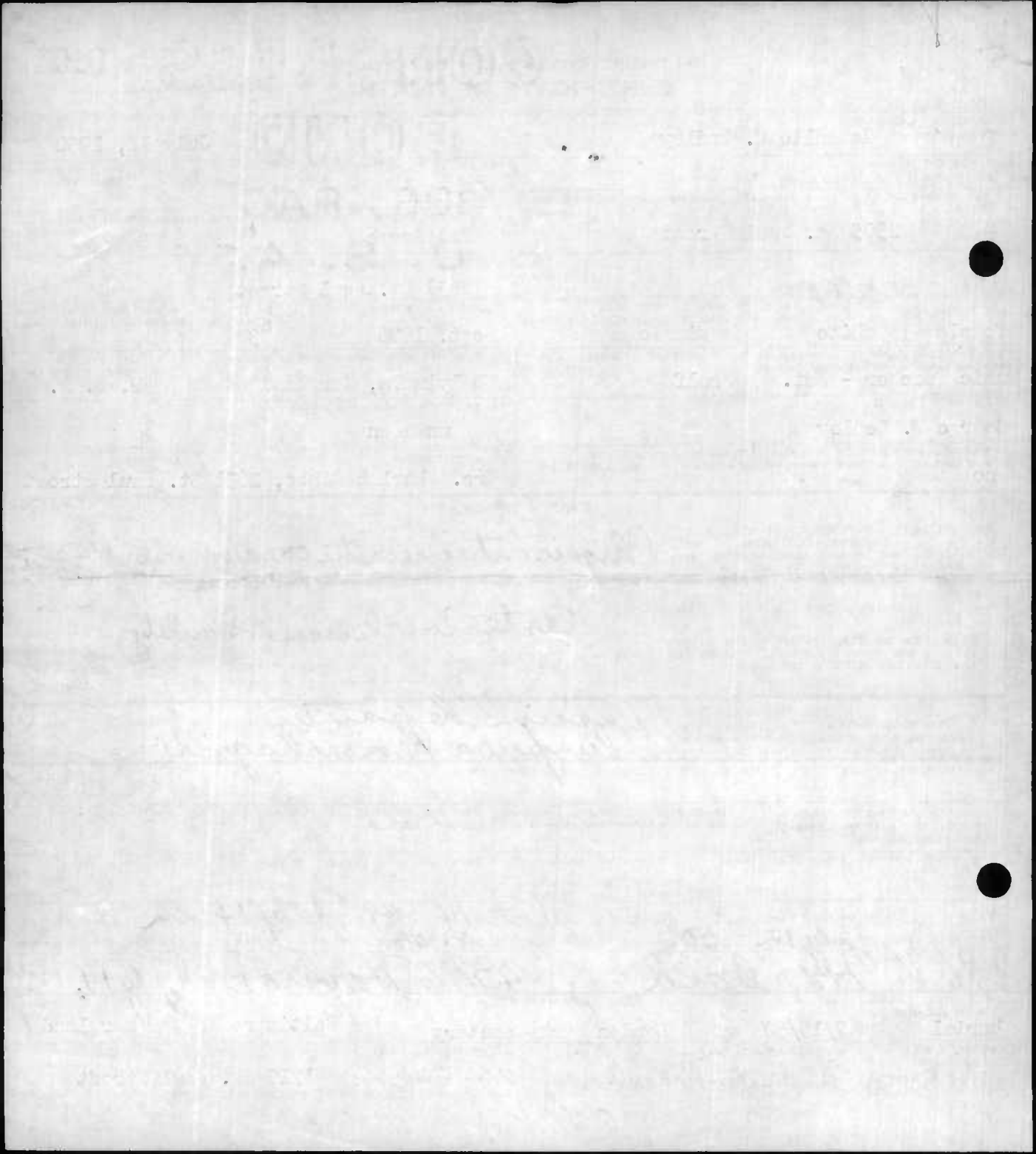
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 15 1950</b>		REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>	
				ADDRESS <b>1217 St. Paul Street</b>	

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MEDICAL CERTIFICATION



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50 6195

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6195  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MARION KUSIK</b>		2. DATE OF DEATH <b>July 14, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Franklin Square Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>44 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>410 S. Bouldin Street</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>August 15, 1888</b>
9. AGE (In years last birthday) <b>61</b>		10. Under 1 Year Months: Days:    11. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Park Board</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harwell Kusik</b>		14. MOTHER'S MAIDEN NAME <b>Gustie Pysz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. John Kusik, 2001 Gough Street</b>		ADDRESS	

18. <b>E812.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple skull fractures with lacerations of the brain</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Washington Blvd. near Monroe Street</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 14, 1950 4.00p.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>R. H. Fisher</b>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/> M. D.		23C. DATE SIGNED <b>July 15, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 18, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Mary</b>	24D. LOCATION (City, town or county) (State) <b>Baltimore Maryland</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		25. FUNERAL DIRECTOR <b>M. F. Sadowski &amp; Sons, 1809 Eastern Avenue</b>	

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6196  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>CHARLES A. LEE</b>		2. DATE OF DEATH <b>July 13, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1811 E. Lafayette Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1811 E. Lafayette Avenue</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 29, 1877</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	9. AGE (in years last birthday) <b>73</b>
13. FATHER'S NAME <b>Robert E. Lee</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>216-05-1905A</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Cummings</b>	
17. INFORMANT <b>1811 E. Lafayette Ave.</b> <b>A. Mrs. Frances A. Lee</b>			

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>Cardiac Hypertensive Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>4 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 27, 1950</b> to <b>July 13, 1950</b> , that I last saw the deceased alive on <b>July 13, 1950</b> , and that death occurred at <b>805A</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Albert Eisenberg</b>		23B. ADDRESS <b>2025 E North Ave</b>		23C. DATE SIGNED <b>July 13, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/15/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b> <b>BALTIMORE - 13, MD</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 15 1950</b>		REGISTRAR'S SIGNATURE <b>Walter for Williams, M.D.</b>		ADDRESS <b>See J. Sander</b>	

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000  
50 6197BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6197

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Grover C. Lee

2. DATE  
OF  
DEATH

July 11, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

509 W. Hoffman St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN  
Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

509 W. Hoffman St.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Dec. 15, 1887

9. AGE (In years,  
last birthday)

62

If Under 1 Year

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Store

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Robert E. Lee

14. MOTHER'S MAIDEN NAME

Mary McCoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.17. INFORMANT  
ADDRESS  
M's Annie L. Preston 509 W. Hoffman

18. 592X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Apoplexy

2 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

Chronic Bright's Disease

2 yrs

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) .....

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 5, 1950, to July 11, 1950, that I last saw the deceased alive on July 10, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-15, 1950

Mt. Auburn Cem

Baltimore

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

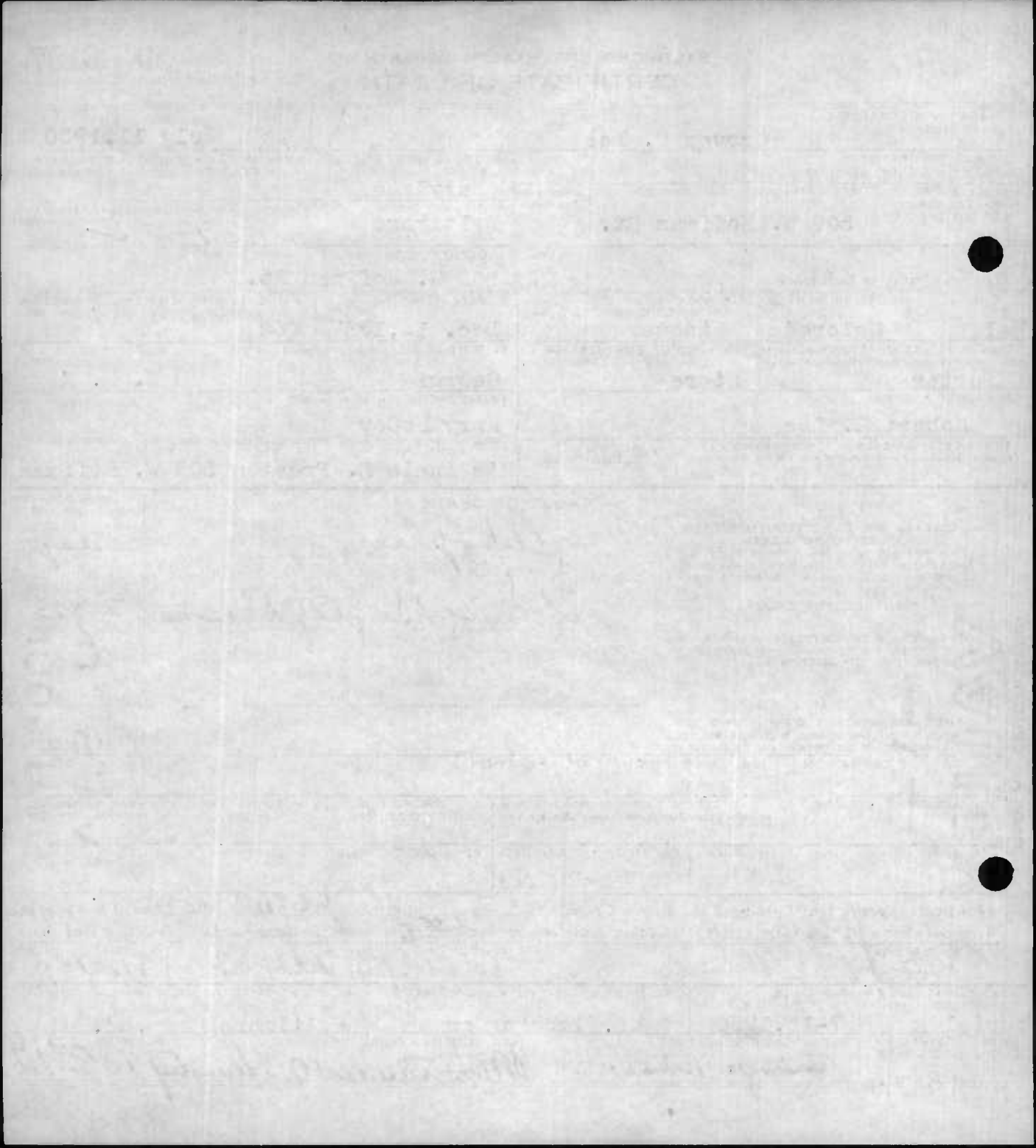
JUL 15 1950

Ruth W. Williams, M.D.

Mettrance G. Hendley W. Biddle

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6198BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6198  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANNA C. WHITTE-MORE

2. DATE  
OF  
DEATH

July 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Mercy Hospital

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

73

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

Same

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Joseph Wright

14. MOTHER'S MAIDEN NAME

Margaret Blake

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Louella Winston 237 Patuxent Ave

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Anterograde cardio-vascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

## CERTIFICATION APPROVED BY

R. S. Fisher

M. D.

CHIEF OR ASS. MEDICAL EXAMINER

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Anterior fracture of femur 16 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

Accident

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

237 Patuxent Ave,

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

6 28 50

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

While making bed

22. I hereby certify that I attended the deceased from July 1, 1950, to July 14, 1950, that I last saw the deceased alive on July 14, 1950, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Charles R. Ireland

M. O.

23B. ADDRESS

Mercy Hospital

23C. DATE SIGNED

July 14, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/17/50

24C. NAME OF CEMETERY OR CREMATORY

Cathedral Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

JUL 15 1950

REGISTRAR'S SIGNATURE

L. W. Neumann, M.D.

25. FUNERAL DIRECTOR

H. W. Neumann - 805 N. Calvert St.

ADDRESS

ask if external condition  
was underlying or contributing  
to death

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6199

253  
0 6199  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Regina, Rosenthal</u>		2. DATE OF DEATH <u>7-13-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>2844 Pelham Av</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>2844 Pelham Ave</u> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>INSTITUTION</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto 27-01</u>	
c. Length of stay in Baltimore <u>69 yrs</u>		D. STREET ADDRESS (If rural, give location) <u>Ind</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>2-3-1873</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>John. Rosenthal</u>		11. BIRTHPLACE (State or foreign country) <u>Lib on on Pa.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		14. MOTHER'S MAIDEN NAME <u>Regina Keebler</u>	
17. INFORMANT <u>Mr. John Rosenthal</u>		ADDRESS <u>3113 Ravenswood Dr</u>	

18. <u>153 X 1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of colon</u>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>0</u>	19B. MAJOR FINDINGS OF OPERATION <u>Generalised carcinoma of peritoneum</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-4, 1948 to 7-13, 1950, that I last saw the deceased alive on 7-13, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE <u>Milton C. Rau</u>	23B. ADDRESS M. D. <u>2117 Belair Rd</u>	23C. DATE SIGNED <u>7-13-50</u>
--	---	------------------------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u>	24B. DATE <u>July 17-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem</u>	24D. LOCATION (City, town, or county) (State) <u>Balto Ind</u>
--	--------------------------------	---	---

DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 15 1950</u>	REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>For J. Herr + Co on 3001 Kentucky Ave</u>
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CERTIFICATE OF DEATH

WALLEY

CONCERN

OF

THE

STATE

OF

NEW



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6200

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**ANSEL WILLIAM EHRMAN**

2. DATE OF DEATH **13 July 18/ 1950.**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland **4816 Wilern Ave.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md** B. COUNTY \_\_\_\_\_

B. FULL NAME OF HOSPITAL OR INSTITUTION \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Balto**

c. Length of stay in Baltimore **Lifetime**

D. STREET ADDRESS (If rural, give location)  
**4816 Wilern ave**

5. SEX **Male** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married**

8. DATE OF BIRTH **June 5th, 1883** 9. AGE (In years, last birthday) **67** 10. Under 1 Year Months: **1** Days: **8** 11. Under 24 Hours Hours: \_\_\_\_\_ Min: \_\_\_\_\_

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **retired** 10B. KIND OF BUSINESS OR INDUSTRY **Buyer Sport Goods**

11. BIRTHPLACE (State or foreign country) **Balto. Md.** 12. CITIZEN OF WHAT COUNTRY? \_\_\_\_\_

13. FATHER'S NAME **Benjamain Ehrman**

14. MOTHER'S MAIDEN NAME **Adaline Wurtzburger**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_

17. INFORMANT **me** ADDRESS **A.W. Ehrman, 4816 Wilern Ave/**

18. **420.1** I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) **Coronary thrombosis** (A) DUE TO \_\_\_\_\_

ANTECEDENT CAUSES (B) DUE TO **Arteriosclerosis** \_\_\_\_\_

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH **Sudden death** **10 years**

19A. DATE OF OPERATION \_\_\_\_\_ 19B. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) \_\_\_\_\_ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME (Month) (Day) (Year) (Hour) INJURY \_\_\_\_\_ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from **7 am**, 19**50**, to **death**, 19**50**, that I last saw the deceased alive on **July 11**, 19**50**, and that death occurred at **11** m., from the causes and on the date stated above.

23A. SIGNATURE **Alan Bernstein** M. D. 23B. ADDRESS **1109 N. Calvert St.** 23C. DATE SIGNED **7/14/50**

24A. BURIAL, CREMATION, or other disposal (Specify) **Burial.** 24B. DATE **July 16/50.** 24C. NAME OF CEMETERY OR CREMATORY **Hebrew Friendship** 24D. LOCATION (City, town, or county) (State) **Balto. Md.**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 15 1950** REGISTRAR'S SIGNATURE **Thurston Williams, M.D.** 25. FUNERAL DIRECTOR **David Sondheim** ADDRESS **1902 Eutaw Pl.**

VS 150

**28060**

**94a**

MEDICAL CERTIFICATION

44728

100

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

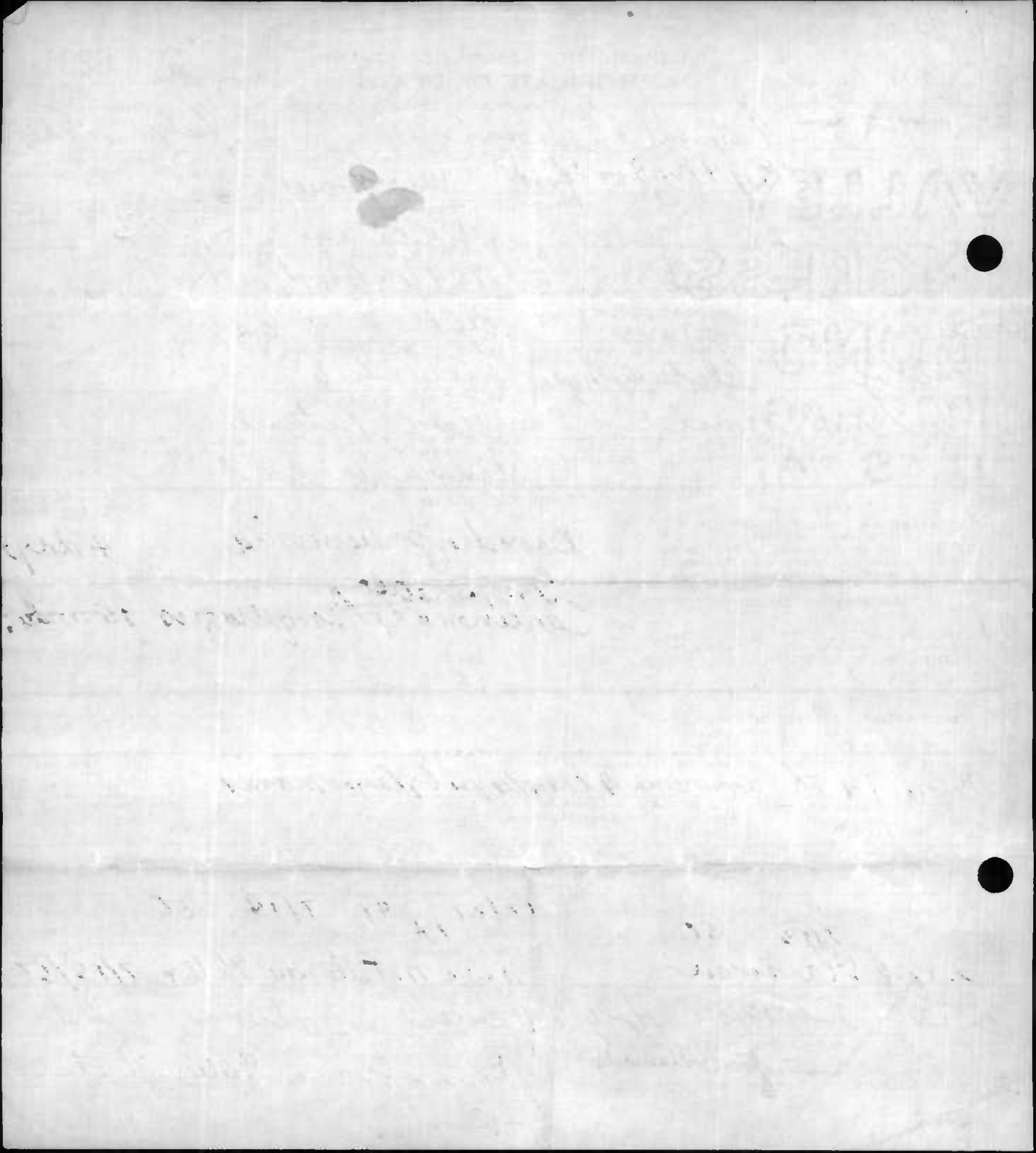
Registered No. **50 6201**

BIRTH NO. <b>50 6201</b>		1. NAME OF DECEASED (Type or Print) <b>James J. Soul</b>		2. DATE OF DEATH <b>July 17, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>904 N. Bradford</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 7-03</b>			
c. Length of stay in Baltimore <b>62</b>		D. STREET ADDRESS (If rural, give location) <b>904 N. Bradford St</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Sept 1</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sector</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Acacia</b>	
13. FATHER'S NAME <b>Michael Soul</b>		14. MOTHER'S MAIDEN NAME <b>Mary Petran</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Anna M. Soul</b>	
				ADDRESS	

18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <b>Bronchopneumonia</b>		DUE TO		<b>4 days</b>	
ANTECEDENT CAUSES		(B) <b>Inoperable Carcinoma of Esophagus</b>		<b>15 months</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <b>Feb. 1, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Compression of esophagus by large masses</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>12/27, 1948</b> to <b>7/14, 1950</b> that I last saw the deceased alive on <b>7/13, 1950</b> and that death occurred at <b>1A</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>G. Karl Grossman</b>		23B. ADDRESS <b>1212 N. Patterson Ph. Ave</b>		23C. DATE SIGNED <b>7/15/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>July 17/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Md</b>		24E. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24F. LOCATION (City, town, or county) <b>Baltimore Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 15 1950</b>		REGISTRAR'S SIGNATURE <b>Winifred Williams</b>		25. FUNERAL DIRECTOR <b>Frank Crach</b>	
				ADDRESS <b>900 N. Chester St</b>	

MEDICAL CERTIFICATION



624  
6202

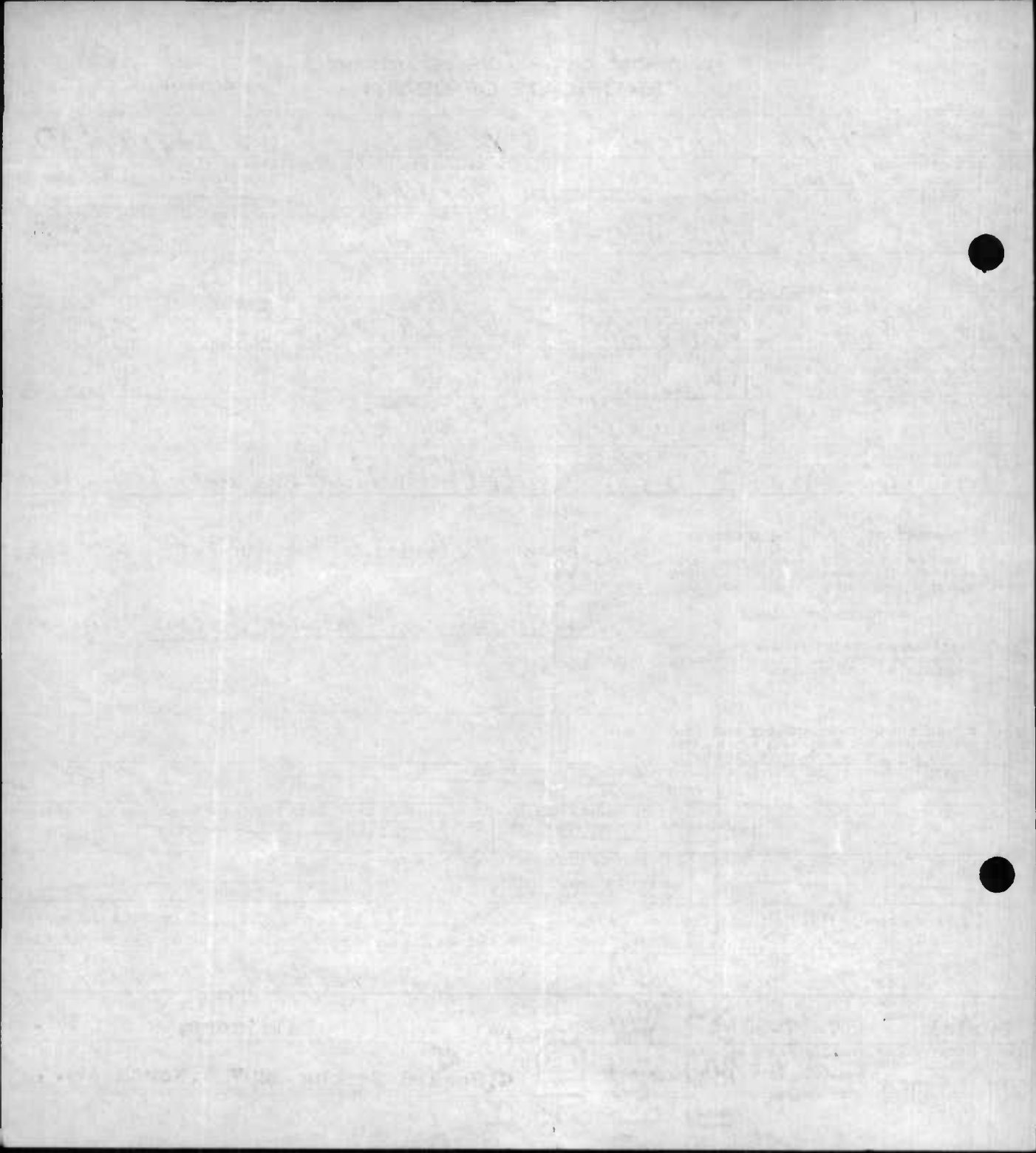
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6202  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>William Joseph Dresse</i>		2. DATE OF DEATH <i>July 14, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2212 Roslyn Avenue - 16 -</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore - 16 - 15-080</i>	
C. LENGTH OF STAY IN BALTIMORE <i>30</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2212 Roslyn Avenue</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 25, 1890</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Grocery</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>A.P. TEACo.</i>	9. AGE (In years last birthday) <i>60</i>
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>United States</i>	
13. FATHER'S NAME <i>William J Dresse</i>		14. MOTHER'S MAIDEN NAME <i>Augusting ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes World War I</i>		16. SOCIAL SECURITY NO. <i>315-03-6869</i>	
17. INFORMANT <i>Mrs. Helen M. Dresse</i>		ADDRESS <i>2212 Roslyn Ave - 16 -</i>	
18. 443 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Asthmatic bronchitis</i> DUE TO CAUSE OF DEATH <i>Hypertensive cardiovascular disease</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>28 years</i> <i>10 years</i>			
19. DATE OF OPERATION <i>0</i>			
19A. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 1949</i> , to <i>July</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 10</i> , 19 <i>50</i> , and that death occurred at <i>5 A.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>William T. Tralund</i>		23B. ADDRESS <i>3400 Woodbine Ave. Balt. 2, Md.</i>	
23C. DATE SIGNED <i>7/14/50</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-17-50</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25. FUNERAL DIRECTOR <i>G. Howard Strong</i>		ADDRESS <i>3207 W. North Ave.,</i>	
26. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 15 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. Williams</i>	

MEDICAL CERTIFICATION

2906A 202 937





520  
0 6203

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6203  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Veronica Jany ska</i>		2. DATE OF DEATH <i>July 14 1950</i>	
3. PLACE OF DEATH A. Baltimore City, <i>Edmon Drankins Jr. Road 17th</i>		USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) B. COUNTY <i>Md.</i> C. CITY OR TOWN <i>Balti.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Shads Nursing Home</i>		D. STREET ADDRESS (If rural, give location) <i>112 Winfred Ave 5300</i>	
c. Length of stay in Baltimore Yrs. Mos. Days		E. DATE OF BIRTH <i>2-14-1859</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Widowed</i>	9. AGE (in years; last birth day) <i>91</i>
10A. USUAL OCCUPATION (Give kind of occupation during most of working life, or if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13. FATHER'S NAME <i>Not Known</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Paul Jany ska</i>		ADDRESS <i>112 Winfred Ave</i>	

18. *E902.71*  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
*Arterio Sclerosis*  
DUE TO  
ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
*Chronic Myocarditis*  
DUE TO  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  
*None*

INTERVAL BETWEEN ONSET AND DEATH  
*846*  
*1946*

CERTIFICATION APPROVED BY  
*B. J. Fisher* M.D.  
CHIEF OR ASST. MEDICAL EXAMINER  
*June 1950*

19A. DATE OF OPERATION  
*June 1, 1950*  
19B. MAJOR FINDINGS OF OPERATION  
*None*

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  
*Accident*  
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  
*home*  
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
*112 Winfred Ave. Co. Landsdown, Md.*  
21D. TIME (Month) (Day) (Year) (Hour) INJURY  
*June 1, 1950 10 a. m.*  
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒  
*While sitting on edge of bed she slipped*  
21F. HOW DID INJURY OCCUR?  
*to floor*

22. I hereby certify that I attended the deceased from *1946*, 19, to *1950*, 19, that I last saw the deceased alive on *July 13, 1950*, and that death occurred at *945 AM* from the causes and on the date stated above.

23A. SIGNATURE  
*W. S. Farson* M. D.  
23B. ADDRESS  
*1711 Selma Ave*  
23C. DATE SIGNED  
*7/14/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*  
24B. DATE  
*7-17-50*  
24C. NAME OF CEMETERY OR CREMATORY  
*St. Augustine*  
24D. LOCATION (City, town, or county) (State)  
*Elkridge Md*

DATE RECEIVED BY LOCAL REGISTRAR  
*JUL 15 1950*  
REGISTRAR'S SIGNATURE  
*Wilmington Williams, Md*  
FUNERAL DIRECTOR  
*George A. Farley*  
ADDRESS  
*Fulton & Fayette*

VS 150  
*14-821.1*  
*186a*



320  
50 6204  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

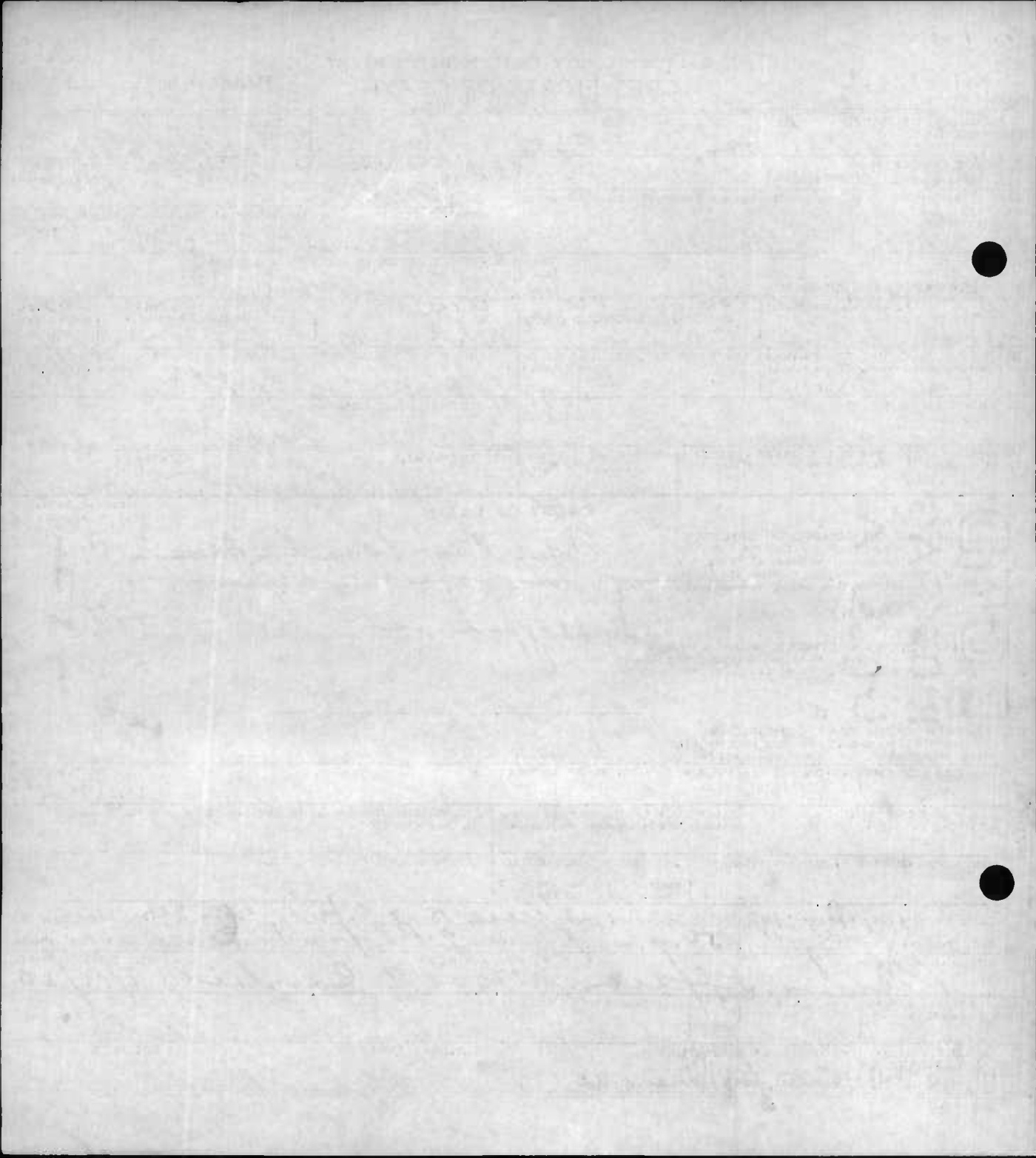
50 6204

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Mary L. Tate</i>		2. DATE OF DEATH <i>July 12, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>19-01</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>411 N. Calhoun St.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>411 N. Calhoun St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Feb. 16, 1870</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <i>80</i>
11. BIRTHPLACE (State or foreign country) <i>Baltimore County Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Frederic Brown</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Sedonia Davis</i>		ADDRESS <i>411 N. Calhoun St.</i>	

18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH (A) <i>Cardio-Vascular Disease ?</i> DUE TO  INTERVAL BETWEEN ONSET AND DEATH  ANTECEDENT CAUSES (B) <i>Hypertension</i> DUE TO  (C) _____  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
---

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 15, 1950</i> to <i>July 12, 1950</i> , that I last saw the deceased alive on <i>July 11, 1950</i> , and that death occurred at <i>2 P. M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Bernard J. Hahn</i>		23B. ADDRESS <i>1702 N. Caroline St.</i>		23C. DATE SIGNED <i>7/15/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 15, 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sharp St. Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Chase Md</i>		24E. NAME OF CEMETERY OR CREMATORY		24F. LOCATION (City, town, or county) (State)	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 15 1950</i>		REGISTRAR'S SIGNATURE <i>Timothy Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Mrs. Robert G. Ellis &amp; Daughter</i>	
				ADDRESS <i>127 N. Caroline St. 931</i>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6205  
Registered No. \_\_\_\_\_

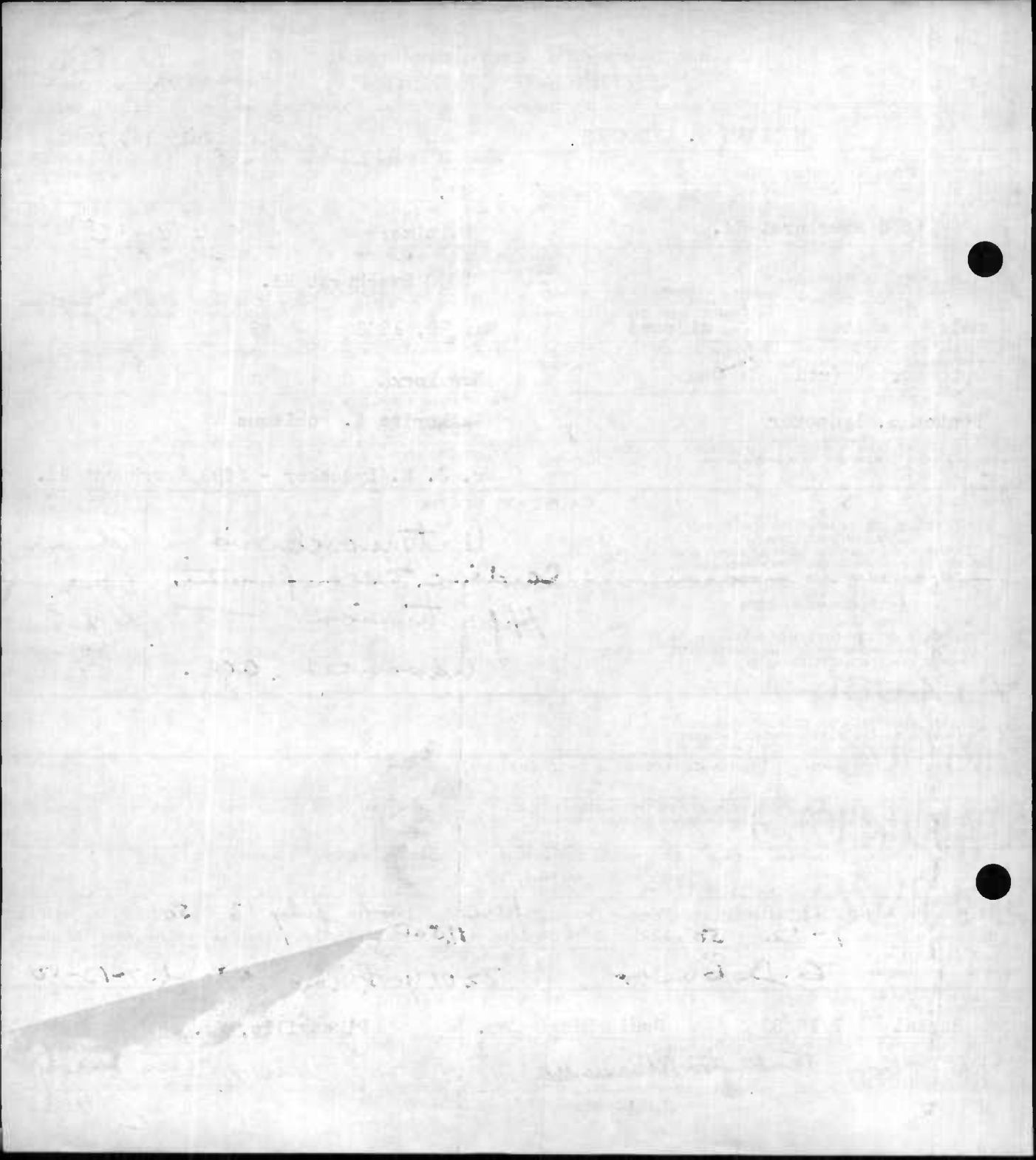
326  
50 6205  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WILLIAM S. LYDECKER</b>		2. DATE OF DEATH <b>July 12, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>5600 Everhurst Rd.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-15</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>5600 Everhurst Rd.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>May 29, 1862</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Optometrist (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own</b>	9. AGE (in years last birthday) <b>88</b>
13. FATHER'S NAME <b>Fenton S. Lydecker</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		16. SOCIAL SECURITY NO. _____	
12. CITIZEN OF WHAT COUNTRY? _____		14. MOTHER'S MAIDEN NAME <b>Catherine E. Pohlemus</b>	
17. INFORMANT <b>Mr. J. M. Lydecker - 5600 Everhurst Rd.</b>		ADDRESS _____	

18. <b>443 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) <b>Arteriosclerosis</b> DUE TO <b>Cardiac Decompensation</b> (B) <b>Hypertension</b> DUE TO _____ (C) <b>Advanced age</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Subsided</b> <b>6 mos.</b> <b>6 yrs</b>
	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	
	19a. DATE OF OPERATION <b>0</b> 19b. MAJOR FINDINGS OF OPERATION _____	

20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21d. TIME (Month) (Day) (Year) (Hour) INJURY _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <b>Jan</b> , 1944 to <b>July 12</b> , 1950 that I last saw the deceased alive on <b>7-12</b> , 1950 and that death occurred at <b>11:50 P.M.</b> , from the causes and on the date stated above.		
23a. SIGNATURE <b>E. B. Emsor</b> M.D.	23b. ADDRESS <b>2201 York Rd. Baltimore, Md.</b>	23c. DATE SIGNED <b>7-13-50</b>

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>7/15/50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 15 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. J. Vickner</b> ADDRESS <b>1400 Balto Md.</b>	





D-120  
50 6206  
CERTIFICATE CORRECTED 7-21-50BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHX50 6206  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mae</i> <i>Ellie Davis</i>			2. DATE OF DEATH <i>July 14, 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Davis</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Va.</i> B. COUNTY <i>V-43</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Comers Rock</i>		
6. LENGTH OF STAY IN BALTIMORE			D. STREET ADDRESS (If rural, give location)		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>5-30-3</i>		9. AGE (in years last birthday) <i>47</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Housekeeping</i>	11. BIRTHPLACE (State or foreign country) <i>Comers Rock, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James K. Poole</i>			14. MOTHER'S MAIDEN NAME <i>Carolyn Delp</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		

18. <i>355X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Internal hydrocephalus</i> (A) <i>Obstruction, aqueduct of Sylvius</i> (B) <i>unducted neoplasm?</i> (C) <i>structure?</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i> <i>(Uver)</i> <i>"</i>	19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
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19A. DATE OF OPERATION <i>June 21, 1950</i>		19B. MAJOR FINDINGS OF OPERATION <i>intraventricular hemorrhage</i>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *6-11* *1950* to *7-14*, 1950, that I last saw the deceased alive on *7-14*, 1950, and that death occurred at *8:30 p.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Maurice L. Oliver</i>	23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	23C. DATE SIGNED <i>7/15/50</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>July 17, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Shuler</i>	24D. LOCATION (City, town, or County) (State) <i>Comers Rock, Va. Va</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>10-10-1950</i>		25. FUNERAL DIRECTOR ADDRESS <i>Ullrich Funeral Home 2004 Ogle</i>	

quency of, when autopsy findings  
are available, we may be  
advised regarding suspected  
neoplasm.

See Document File 50-6206

Anatomical Diagnosis made no mention of malignancy

1/17/1951 E.S.

H-655 50 6207  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6207  
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
MORRIS HERMAN		July 14, 1950	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. FULL NAME OF (If not in hospital or institution, give street address or location)		A. STATE	
4102 Woodhaven Avenue		Maryland	
c. Length of stay in Baltimore		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
Yrs. Mos. Days		Baltimore 15-09	
5. SEX		D. STREET ADDRESS (If rural, give location)	
Male	6. COLOR OR RACE	4102 Woodhaven Avenue	
White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	
	Married	1889	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	
Sheet Metal Worker		61	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Own Business		Poland	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Samuel Herman		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)			
17. INFORMANT		ADDRESS	
Mrs. Esther Herman		4238 Woodhaven Ave.	

18. 420.0 I	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) DUE TO	Cerebral embolism	3 days
ANTECEDENT CAUSES	(B) DUE TO	arteriosclerotic heart disease	1 year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
INJURY	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	

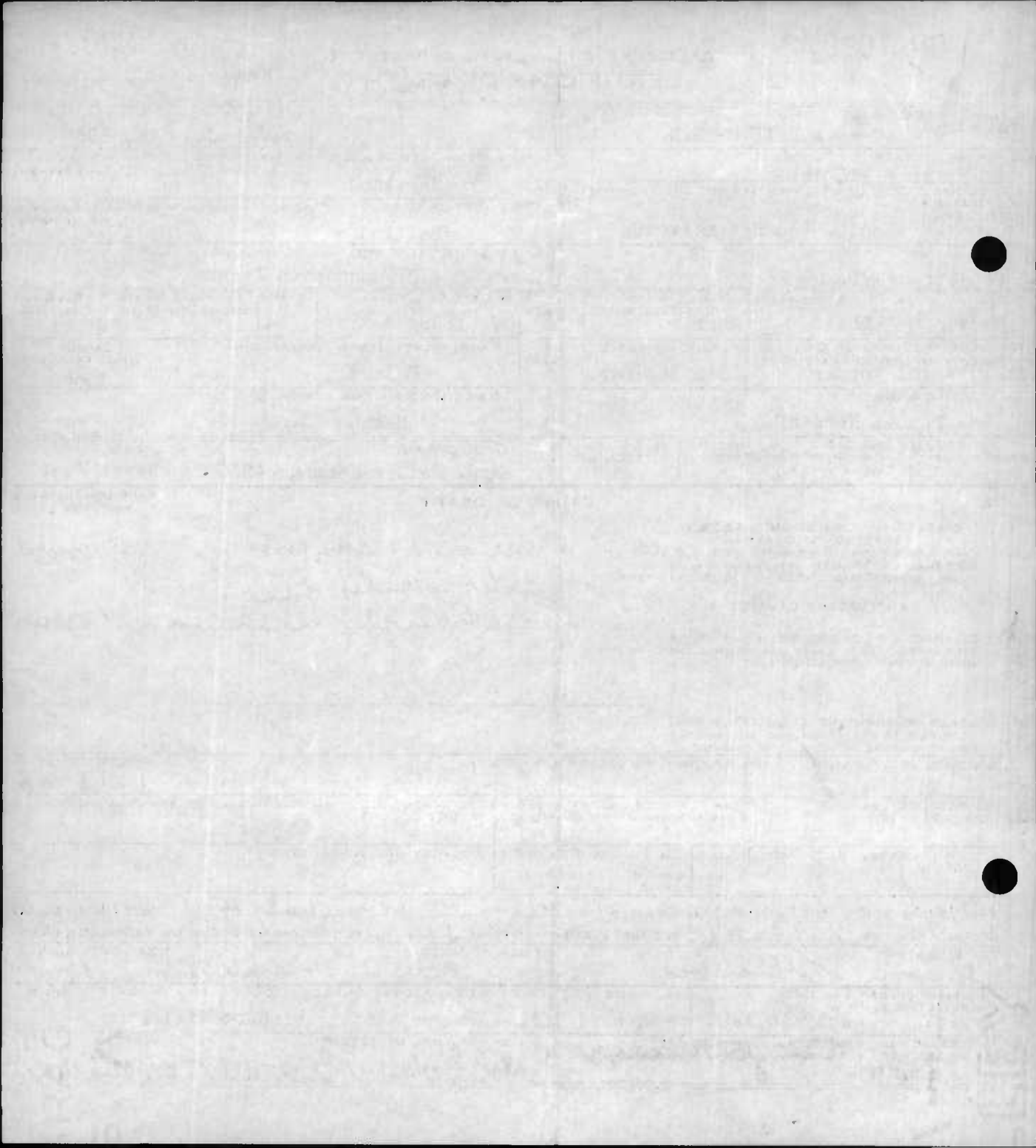
22. I hereby certify that I attended the deceased from Jan 10, 1940 to July 14, 1950, that I last saw the deceased alive on 7-13, 1950 and that death occurred at 1 p.m., from the causes and on the date stated above.

23A. SIGNATURE *Erwin Sauter* M. O. 23B. ADDRESS 3003 Juniper Ave 23C. DATE SIGNED 7-14-50

24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 16, 1950	Shaarei Tfiloh Congregation	Windsor Mill Road
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 16 1950	<i>Richard H. Williams, M.D.</i>	Sol Levinson & Bros.	1124-26 W. North Ave. 17

VS 150  
5913E 207 937

MEDICAL CERTIFICATION



T-460  
50 6208BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6208  
Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Jessie V. Taylor

2. DATE  
OF  
DEATH

7/13/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

6014 Prescott Ave

Yrs.  
Mos.  
Days

Life

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, oo or uokooow) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 422.2

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) Myocarditis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 0 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from 3-13-1950 to 7-13-1950 that I last saw the deceased alive on 7-13-1950 and that death occurred at 8:30 P m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. GENERAL DIRECTOR

ADDRESS

JUL 16 1950

VS-150

Huntington Williams, M.D.

Samuel W. Sullivan, Jr. 93E  
1011 N. Belington Ave

NO 200

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A-652  
50 6209BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6209  
Registered No.

BIRTH NO.		
1. NAME OF DECEASED (Type or Print) (MARY ARMSTEAD) MARY ELIZABETH ARMSTEAD		2. DATE OF DEATH July 13, 1950
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY
B. FULL NAME OF (If not in hospital or institution, give street address or location) Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-02
C. Length of stay in Baltimore 60		D. STREET ADDRESS (If rural, give location) 515 W. Lanvale Street
5. SEX female	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		8. DATE OF BIRTH 18 7 0
10B. KIND OF BUSINESS OR INDUSTRY Housework		9. AGE (In years last birthday) 79
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Norfolk Va.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Unknown
17. INFORMANT		ADDRESS
Lillie Brun del - 2029 Mc Culloch St		

18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral thrombosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH Cerebral thrombosis DUE TO DUE TO DUE TO	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. UTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE R. S. Fisher	23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER MEDICAL INVESTIGATOR	23C. DATE SIGNED July 13, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) B.	24B. DATE 7-16-50	24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.	24D. LOCATION (City, town, or county) (State) Balt. Co. Md.
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 16 1950	William W. Williams, Jr.	Samuel W. Sullivan, Jr.	1011 N. Arlington Ave

STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

8-350  
50 6210

Ethudin

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6210

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marilyn Ethudin

2. DATE  
OF  
DEATH

July 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore

Life  
Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Uremia

DUE TO

1 month

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Lupus erythematosus  
disseminatus

DUE TO

7 years

(C)

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m. WHILE AT NOT WHILE  
WORK AT WORK22. I hereby certify that I attended the deceased from 7-3 1950, to 7-14, 1950, that I last saw the  
deceased alive on 7-14, 1950, and that death occurred at 7:40 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 16 1950

Thurston Williams, M.D.

Jack Lewis 2100 Centard Pl

VS 150

153

1950-1951

Handwritten notes and text, mostly illegible due to fading and bleed-through. The text appears to be organized into sections or paragraphs, with some lines being underlined. There are two punch holes visible on the right side of the page.

5-162

50 6211

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6211  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ALONZO SHIVERS</b>			2. DATE OF DEATH <b>July 14, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Provident Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>219 N. Schroeder Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>24</b>	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Winnsboro, South Carolina</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Nathan Shivers</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Rosebough</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Nathan Shivers 219 N. Schoeder St.</b>		

18. <b>E981.X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Bullet wound of left chest with left hemothorax</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1301 Fremont Street</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 14, 1950 8.45p.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input checked="" type="checkbox"/> , undetermined <input type="checkbox"/> .		
23A. SIGNATURE <b>B. B. Fisher</b>	23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED <b>July 15, 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 16, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>	24D. LOCATION (City, town, or county) (State) <b>South Carolina</b>
25. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>	ADDRESS <b>322 N. 166</b>		

JUL 15 1950

N-861.4

97099

166

✓

MEDICAL CERTIFICATION

STATE OF NEW YORK

IN SENATE,  
January 1, 1901.

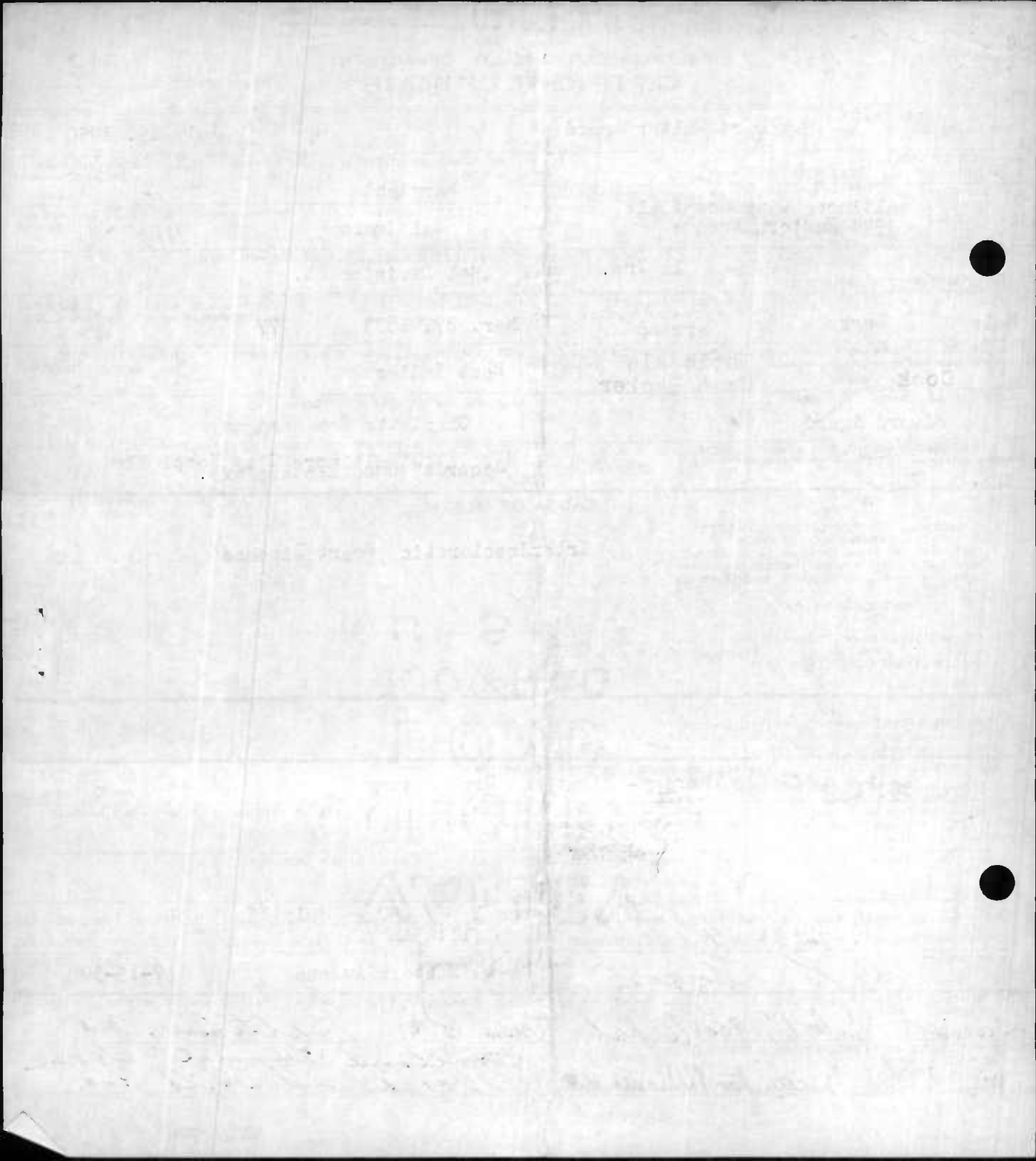
REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE,  
IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899.

ALBANY:  
J. B. LEECH, STATE PRINTER,  
1901.



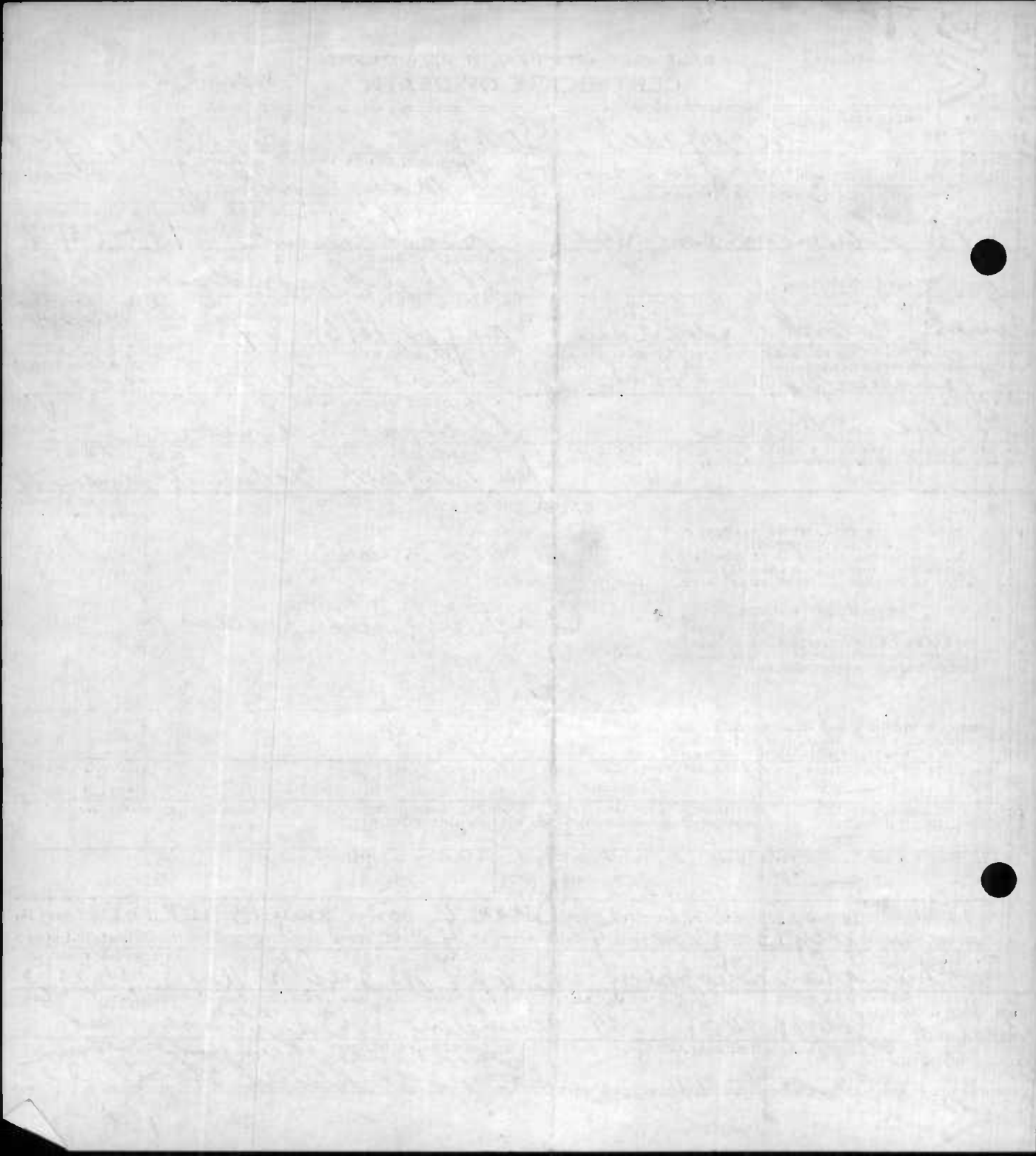
<div style="display: flex; justify-content: space-between;"> <span>LC <b>A-263</b></span> <span><b>CERTIFICATE CORRECTED 8-22-50</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<div style="display: flex; justify-content: space-between;"> <span>136219 50 6212</span> <span>50 6212</span> </div>	
BIRTH NO.		Registered No.			
1. NAME OF DECEASED (Type or Print)		Edward Walter Agard		2. DATE OF DEATH July 15, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02			
c. Length of stay in Baltimore 11 Yrs. Yrs. Mos. Days		O. STREET ADDRESS (If rural, give location) 1541 Division St.			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 27, 1873	9. AGE (In years last birthday) 77	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Meat Packer		11. BIRTHPLACE (State or foreign country) West Indies	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward Agard		14. MOTHER'S MAIDEN NAME Charlotte Von Hanigan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no.		16. SOCIAL SECURITY NO.		17. INFORMANT Baltimore City Hospitals Records* 4940 Eastern Ave.	
18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) Arteriosclerotic Heart Disease DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION March 15, 1950		19B. MAJOR FINDINGS OF OPERATION Therapy- Bilateral Orchiectomy		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 1, 1950, to July 15, 1950, that I last saw the deceased alive on July 11, 1950, and that death occurred at 11:45AM, from the causes and on the date stated above.					
23A. SIGNATURE W. Rozen M. D.		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 7-15-50	
24A. BURIAL, CREMA- TION, REMOVAL (Specify) Burial		24B. DATE July 16, 1950		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		24E. REGISTRAR'S SIGNATURE Wilmington Williams, M.D.		24F. FUNERAL DIRECTOR ADDRESS Holland Funeral Home 1651 Druid Hill Ave.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 16 1950		VS 150			

937



B-600  
50 6213BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6213  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Margaret Berry		July 13, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
Edmondson Ave		Baltimore 16-04			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
		1808 Edmondson Ave.			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Year Months Days
Female	Colored	Widowed	May 12, 1886	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		None		Sancastr C. Va.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
usa		Hiram Russ		Eliza Lemoine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Mrs. Margaret Norton N. Monroe St. 1623	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) 434.1.1		Tobacco Pneumonia		2 day	
DUE TO		(B) Congestive Heart Disease			
DUE TO		(C) Cholecystitis			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
INJURY		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from Mar 6, 1950, to July 13, 1950, that I last saw the deceased alive on July 13, 1950, and that death occurred at 4 P. M., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
J. Douglas Sheppard		604 N. Dulany Ave		7/15/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 16, 1950		Mt. Auburn	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Baltimore, Md.		Hallard		1631 David Hill Ave.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNDAL DIRECTOR	
JUL 16 1950		[Signature]		[Signature]	



652  
50 6214BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6214  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John K. Franz

2. DATE  
OF  
DEATH

4/14/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

210 S. Monastery Ave

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

MALE White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Printer

10B. KIND OF BUSINESS OR  
INDUSTRY

Lord Balto-Pres

13. FATHER'S NAME

John Franz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

No

16. SOCIAL  
SECURITY NO.

215-01-3407 - Theresa E. Rouché - Same

17. INFORMANT

ADDRESS

18. 421.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) ...  
DUE TO

Coronary Occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) ...  
DUE TO

Endocarditis

2

(C) ...  
DUE TO

Chs

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Nephritis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/6, 1948, to 7/13, 1950, that I last saw the  
deceased alive on 7/1, 1950, and that death occurred at 8 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

16 1950

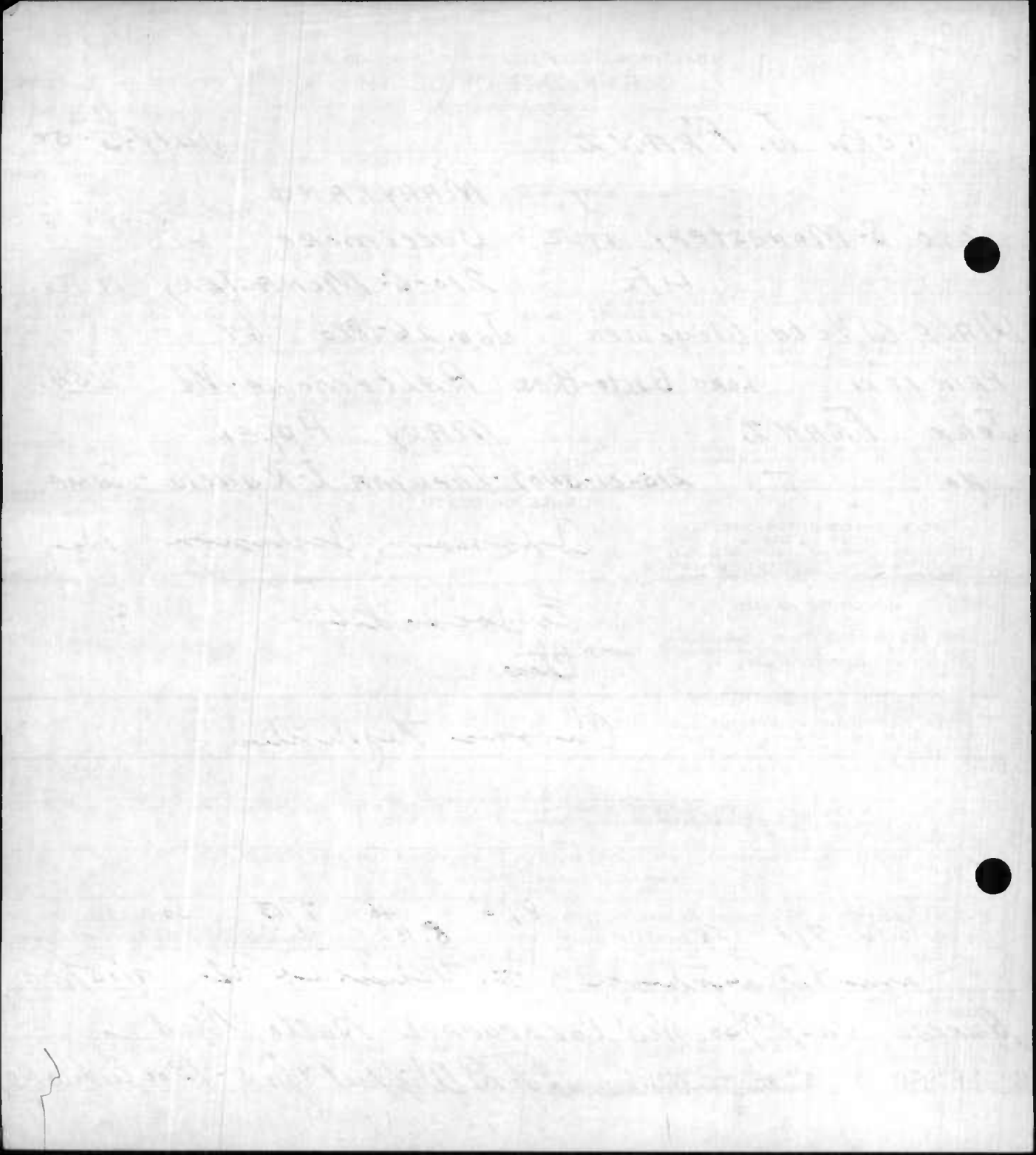
T. B. Whippert &amp; Son - 1300 E. Enoch Rd

VS 150

512414

131B

7





426

50 6215

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6215

Registered No.

BIRTH NO. 50-11098

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Melchior

2. DATE  
OF  
DEATH

June 2, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

md

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

West Balto General Hosp

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Balto 15-

27-17

D. STREET ADDRESS (If rural, give location)

5206 Maple Ave

C. Length of stay in Baltimore

(Mother 24)

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

June 2, 1950

9. AGE (In years,  
last birthday)

10 Under 1 Year  
Months Days

11 Under 24 Hours  
Hours Min.

4 20

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ralph Nelson Melchior

14. MOTHER'S MAIDEN NAME

Shirley Frances Constantine

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mother

5206 Maple Ave

18. 774X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) 1) Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

2) Mongolian Idiot

3) Hermaprodite

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/4, 1950, to 6/4, 1950, that I last saw the  
deceased alive on 6/4, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF NEW YORK

DECEASED

NAME

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Medical Examiner

Signature of Health Officer

Signature of District Attorney

Signature of County Clerk

Signature of City Clerk

Signature of Mayor

Signature of Governor

Signature of President

# CERTIFICATE CORRECTED

7-20-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 6216

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN BARTOZY BARTOSZ

2. DATE  
OF  
DEATH

July 14, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1503 Montpelier Street

C. Length of stay in Baltimore

30 yrs.

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

May 19, 1898

9. AGE (In years  
last birthday)

52 53

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Taylor

10B. KIND OF BUSINESS OR  
INDUSTRY

Labow Bros.

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ferdynad Bartosz

14. MOTHER'S MAIDEN NAME

Bertha Wazowicz

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-09-3820

17. INFORMANT

ADDRESS

Mrs. Howard Stirzel 1229 Ramble-

18. 443X

### CAUSE OF DEATH

WOOD RD.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

R. F. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

July 15, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 17

Parkwood Cemetery

Baltimore

DATE RECEIVED BY  
LOCAL REGISTRAR

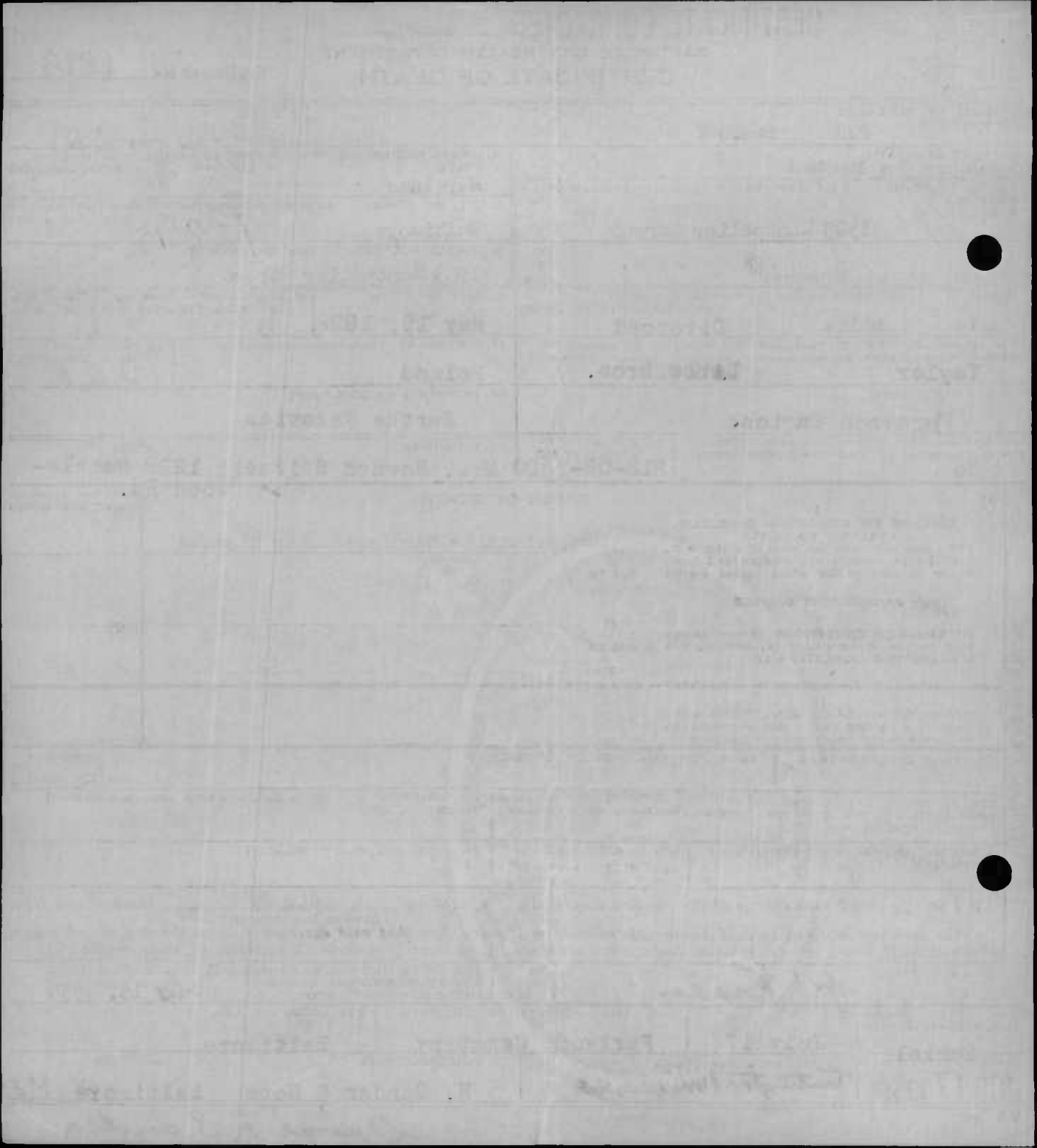
REGISTRAR'S SIGNATURE

Wilmington Williams

25. FUNERAL DIRECTOR

ADDRESS

H. Sander & Sons Baltimore Md



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6217  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Jane Stanley Cook*

2. DATE  
OF  
DEATH

*July 14-1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *745 W. Mulberry St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
STATE \_\_\_\_\_ B. COUNTY \_\_\_\_\_

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, give RURAL and give township)  
*Balto.* *4-02*

c. Length of stay in Baltimore *Life*

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)  
*745 W. Mulberry St*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

*Female Colored*

*Widow*

*1878*

*72*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS *George Hopkins 745 W. Mulberry St*

18. *443X I*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) \_\_\_\_\_

DUE TO

*Hypertensive Corded Vascular Disease*

INTERVAL BETWEEN ONSET AND DEATH

*?*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_

DUE TO

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *12/1/49*, 19\_\_ to *7/14/50*, 19\_\_, that I last saw the deceased alive on *3/14/50*, 19\_\_, and that death occurred at *9:00 A.M.* from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Jul 17 1950*

*William H. Williams, M.D.*

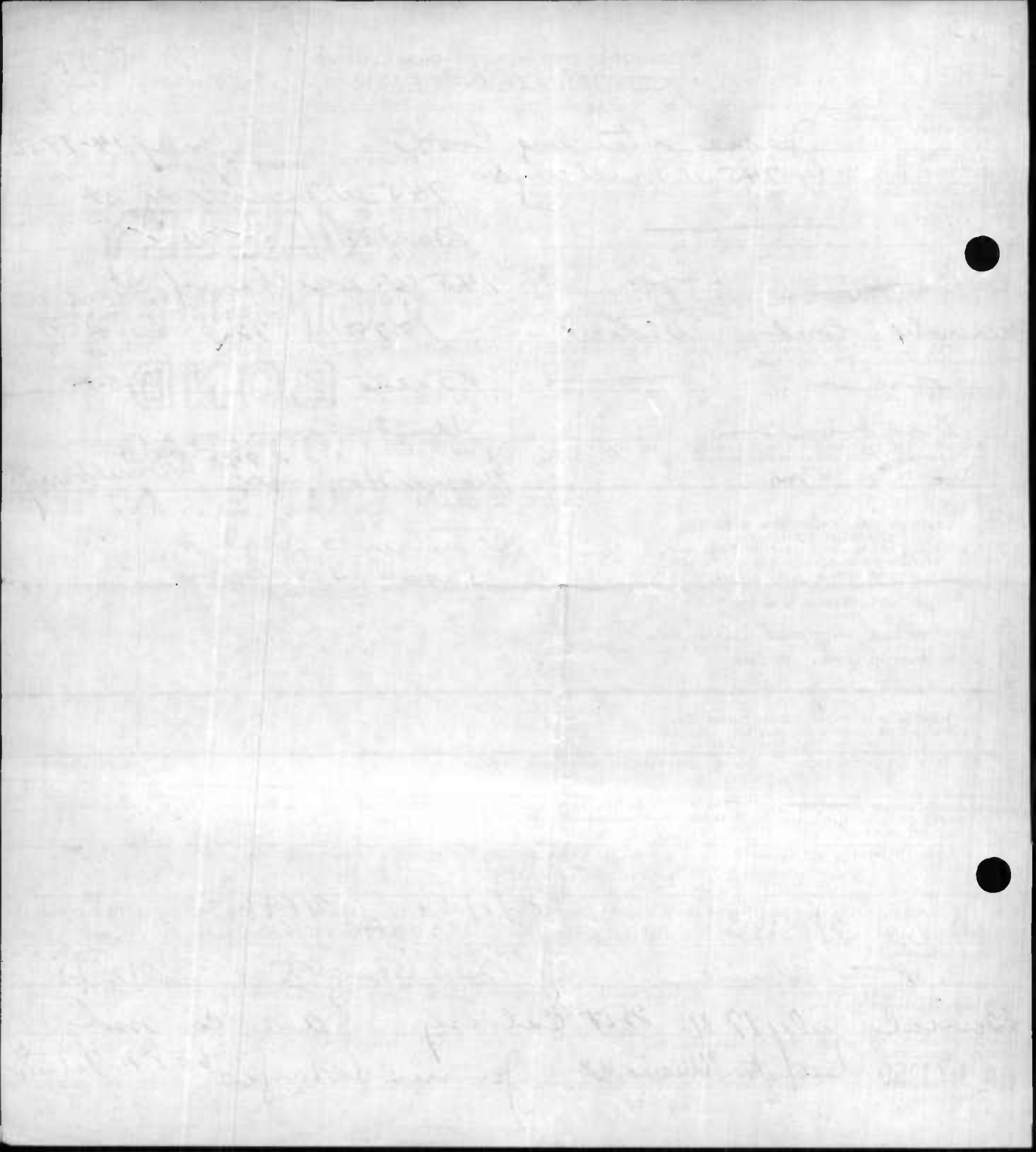
*James A. Hayes*

*638 N. 9th St*

VS 150

*937*

MEDICAL CERTIFICATION

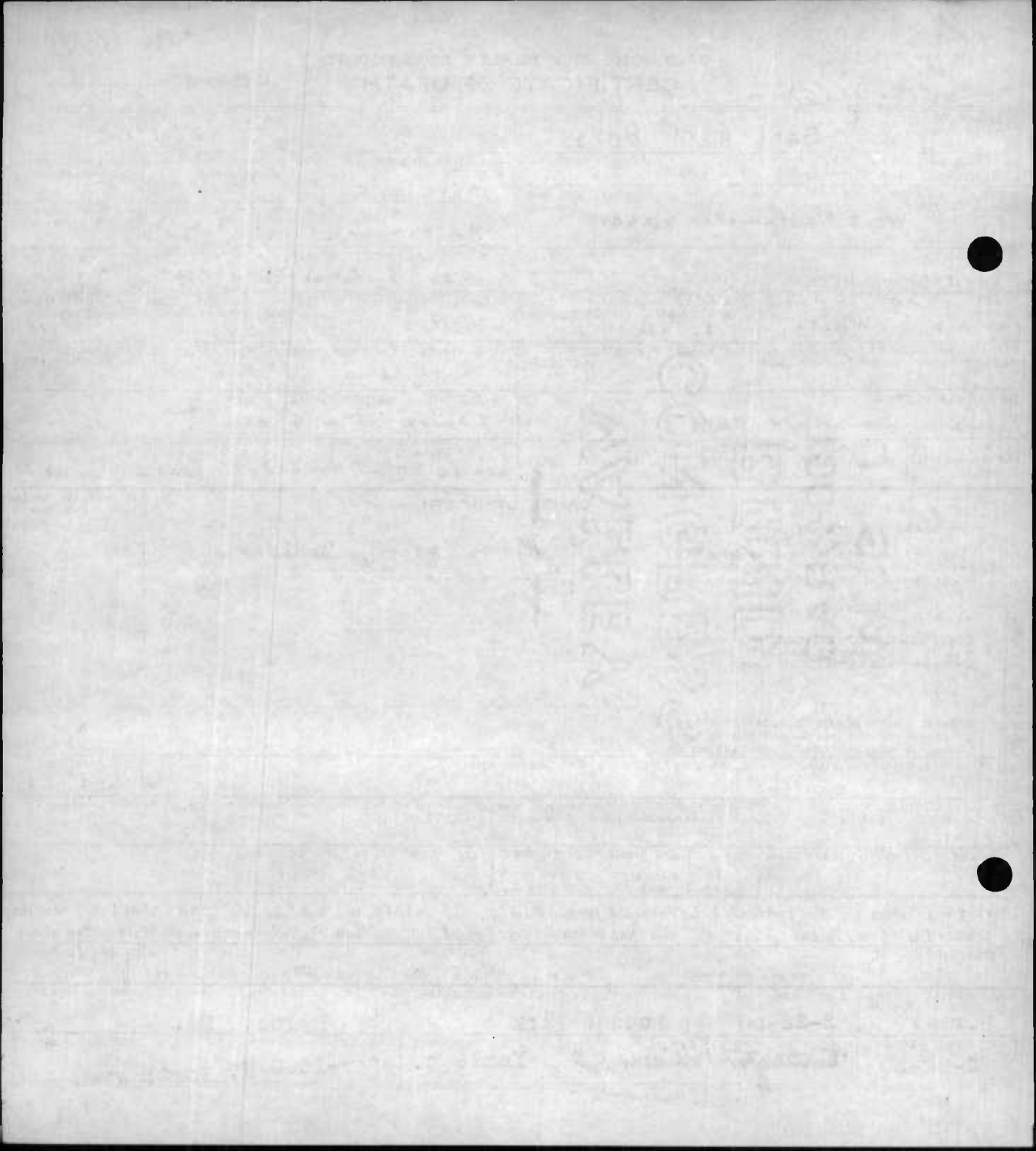




1. NAME OF DECEASED (Type or Print) Baby Girl Herget		2. DATE OF DEATH 2/21/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION West Baltimore General		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-02	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1323 S. Charles Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 2/21/50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years; last birthday) H Under 1 Year Months Days H Under 24 Hours Hours Min. 15
13. FATHER'S NAME Edward Emanuel Herget		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Louise Etta Green	
17. INFORMANT Louise Etta Herget		ADDRESS 1323 S. Charles St	

18. 762.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Atelectasis, Bilateral Primary DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/21, 1950, to 2/21, 1950, that I last saw the deceased alive on 2/21, 1950, and that death occurred at 8 A. M., from the causes and on the date stated above.					
23A. SIGNATURE Helen G. Maguire		23B. ADDRESS 1445 N. Gay St		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 2-22-50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Balto., Md.		25. FUNERAL DIRECTOR Mamie C. Syfer-1600 W. North Ave.		ADDRESS	



352  
0 6219

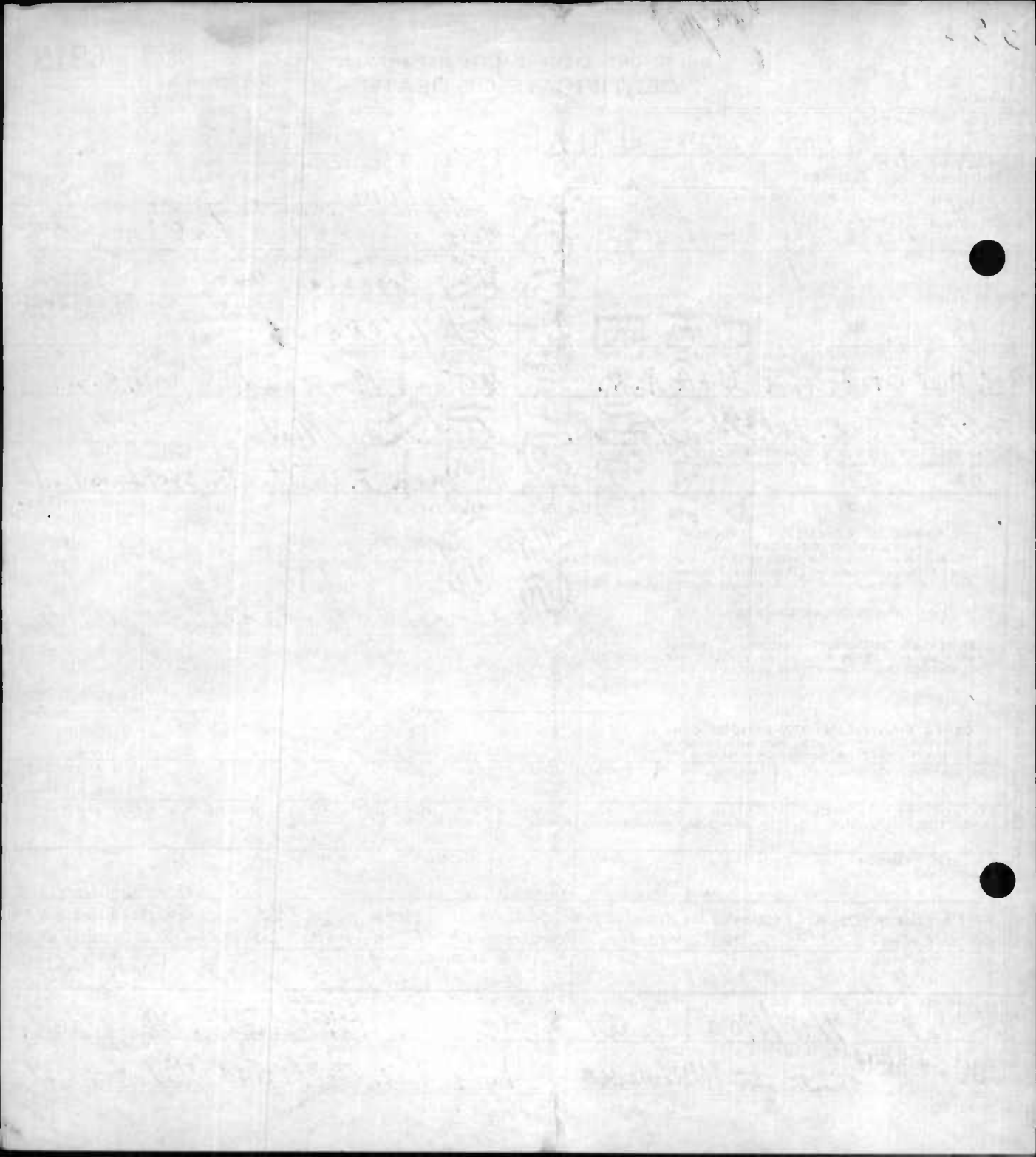
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6219  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>WHITTINGTON, William E.</i>		2. DATE OF DEATH <i>7-15-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balt</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balt 13 8-01</i>	
C. Length of stay in Baltimore Yrs. <i>M</i> Mos. <i>W</i> Days		D. STREET ADDRESS (If rural, give location) <i>3409 Crossland Ave</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Oct. 7, 1883</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Asst. Real Estate Agent</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>B &amp; O. R. R.</i>	9. AGE (In years last birthday) <i>66</i>
11. BIRTHPLACE (State or foreign country) <i>Marion, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William E. Whittington Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Adelia Miles</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>✓</i>	
17. INFORMANT <i>Mrs Anna F. Whittington</i>		ADDRESS <i>3409 Crossland Ave</i>	

18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hyperpyrexia</i> DUE TO <i>Central vascular accident</i> DUE TO <i>13 days</i>		CAUSE OF DEATH <i>Hyperpyrexia</i> <i>Central vascular accident</i> <i>13 days</i>	INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i> <i>13 days</i>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7-10</i> <i>1950</i> , to <i>2-15</i> <i>1950</i> , that I last saw the deceased alive on <i>7-15</i> <i>1950</i> , and that death occurred at <i>8 P</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>George E. Chen</i>		23B. ADDRESS <i>University Hospital</i>		23C. DATE SIGNED <i>7-15-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/18/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>	
24D. LOCATION (City, town, or county) (State) <i>Pikesville, Maryland</i>		24E. FUNERAL DIRECTOR <i>Howard A. Gill</i>		24F. ADDRESS <i>5400 Midwood Ave</i>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6220  
Registered No. \_\_\_\_\_

460  
BIRTH NO. 6220

1. NAME OF DECEASED (Type or Print) <b>JOHN TAYLOR</b>		2. DATE OF DEATH <b>July 14, 1950</b>							
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____							
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Franklin Square Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>18-03</b>							
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1023 Booth St.</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Unknown</b>	8. DATE OF BIRTH <b>— 1892</b>						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	9. AGE (In years last birthday) <b>68 yrs.</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>If Under 1 Year</td> <td>If Under 1 Year</td> <td>If Under 24 Hours</td> </tr> <tr> <td>Months: Days</td> <td>Months: Days</td> <td>Hours: Min.</td> </tr> </table>	If Under 1 Year	If Under 1 Year	If Under 24 Hours	Months: Days	Months: Days	Hours: Min.
If Under 1 Year	If Under 1 Year	If Under 24 Hours							
Months: Days	Months: Days	Hours: Min.							
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.							
17. INFORMANT <b>E. Edith Overton</b>		ADDRESS <b>843 China St</b>							

18. <b>E 812.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Subdural Hematoma</b> DUE TO <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Syphilitic aortitis</b>		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <b>7/17/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Baltimore &amp; Carrollton Ave.</b>		
21D. TIME (Month) (Day) (Year) (Hour) <b>July 14, 1950 2:10 A.M.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by auto</b>		

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>Stanley B. Dunlap</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 14, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/17/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>MT. Calvary Cem. A. A. Co. Ind.</b>		24D. LOCATION (City, town, or county) (State) <b>927 Mount St.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		25. FUNERAL DIRECTOR <b>Huntington Williams, Inc. Metropolitan Funeral Home Inc.</b>		

STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED: [Name] BY: [Name]

[Faint, illegible text in the middle section of the form, likely containing details of the death and burial.]

[Faint, illegible text in the bottom section of the form, likely containing signature lines and dates.]



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6221  
Registered No. \_\_\_\_\_

150  
50 6221  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Ella Dubin</i>		2. DATE OF DEATH <i>7-16-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Sumner</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 27-19</i>	
C. LENGTH OF STAY IN BALTIMORE <i>45</i> Yrs. <input checked="" type="checkbox"/> Moe. <input type="checkbox"/> Days		D. STREET ADDRESS (If rural, give location) <i>5516 Minnoka Ave</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Separated</i>	8. DATE OF BIRTH <i>60</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>60</i>
11. BIRTHPLACE (State or foreign country) <i>Latvia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>NOT KNOWN</i>		14. MOTHER'S MAIDEN NAME <i>NOT KNOWN</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Charles Dubin - same</i>		ADDRESS	

18. <i>153 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Diffuse carcinomatous</i> DUE TO (B) <i>Carcinoma of colon.</i> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 15, 1950</i> to <i>July 16, 1950</i> that I last saw the deceased alive on <i>July 16, 1950</i> and that death occurred at <i>9:00 AM.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Samuel H. Rubin</i> M. D.		23B. ADDRESS <i>Sumner Hospital</i>		23C. DATE SIGNED <i>July 16, 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-17-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Beth Tfiloh</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Md</i>		25. FUNERAL DIRECTOR <i>Jack Lewis</i> ADDRESS <i>2100 Britton Pl</i>			

MEDICAL CERTIFICATION

RECEIVED  
JAN 10 1964

N

634  
6222BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6222

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WARDWELL, MARGARET BRUNDIGE.</b>		2. DATE OF DEATH <b>JULY 14 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>N. Broadland.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME AND HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 12 27-11</b>	
C. Length of stay in Baltimore <b>LIFE.</b>		D. STREET ADDRESS (If rural, give location) <b>419 WINSTONE AVE</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>EUROPEAN</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAY 25<sup>th</sup> 1879</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	9. AGE (In years last birthday) <b>71 years</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>THOMAS BRUNDIGE</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BROGDEN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Miss Wardwell - 419 Winstone Ave</b>		ADDRESS <b>419 Winstone Ave</b>	
18. CAUSE OF DEATH <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>HYPOSTATIC PNEUMONIA</b> DUE TO <b>14 days</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>CEREBRAL THROMBOSIS</b> DUE TO <b>12 days</b> <b>ARTERIOSCLEROTIC</b> <b>CARDIOVASCULAR DISEASE</b> DUE TO <b>years</b> <b>HYPERTENSIVE</b> " " "		INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>12 days</b> <b>years</b> <b>"</b> <b>"</b> <b>"</b>	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>NONE</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3rd July, 1950</b> , to <b>14 July, 1950</b> , that I last saw the deceased alive on <b>14 July, 1950</b> , and that death occurred at <b>11:15 p.m.</b> from the causes and on the date stated above.			
23A. SIGNATURE <b>W. W. Williams</b>		23B. ADDRESS <b>Church Home Hospital</b>	
23C. DATE SIGNED <b>7/14/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July-17-50</b>		24B. DATE <b>St. John's - York Rd 931 - Balto.</b>	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State) <b>Balto.</b>	
25. FUNERAL DIRECTOR <b>Stewart Monahan - Balto.</b>		ADDRESS <b>Balto.</b>	

July 14 1930

VANDERBILT UNIVERSITY

MILWAUKEE

WISCONSIN

WILSON

MAY 27 1930

MARYLAND

ANNA

BRONCHITIS

THOMAS

HOUSE WIFE

FRANK KNEAN WIDOWED

HYPERTENSIVE PNEUMONIA 11 days

CEREBRAL THROMBOSIS 12 days

ARTERIO-SCLEROTIC CHRONIC RENAL DISEASE

HYPERTENSIVE

Admission to the University of Chicago Hospital 7/14/30

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Harold Schuch

2. DATE  
OF  
DEATH

July 11, 1950

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Child

8. DATE OF BIRTH

10-17-44

9. AGE (in years  
last birthday)

5

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Harold Schuch

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 204.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Hemorrhage, intestinal

2 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Thrombocytopenia

Several  
months

DUE TO

(C)

Acute lymphoid leucemia

14 mos.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21a. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21b. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21e. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-6-50 to 7-11-50, that I last saw the  
deceased alive on 7-11-50, and that death occurred at 8 a.m., from the causes and on the date stated above.

23a. SIGNATURE

Victor A. McKusick

M. D.

23b. ADDRESS

JOHNS HOPKINS HOSPITAL

23c. DATE SIGNED

7-11-50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL

JUL 12 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 17 1950

Curtis W. Williams, M.D.

Commissioner of Health

VS 150

74a

MEDICAL CERTIFICATION

11. ... ..  
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520  
50 6224

LANASA  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6224  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Minnie Lanasa</u>			2. DATE OF DEATH <u>7/15/50</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Baltimore Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>South Baltimore General Hospital</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <u>630 Patapsco Avenue</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>May 23</u>		9. AGE (In years last birthday) <u>45</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>August Balsoma</u>			14. MOTHER'S MAIDEN NAME <u>Vera Boksa</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <u>410X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH <u>CARDIAC FAILURE</u>
ANTECEDENT CAUSES	(A) DUE TO <u>MITRAL + AORTIC STENOSIS</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) DUE TO <u>RHEUMATIC HEART DISEASE</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C)

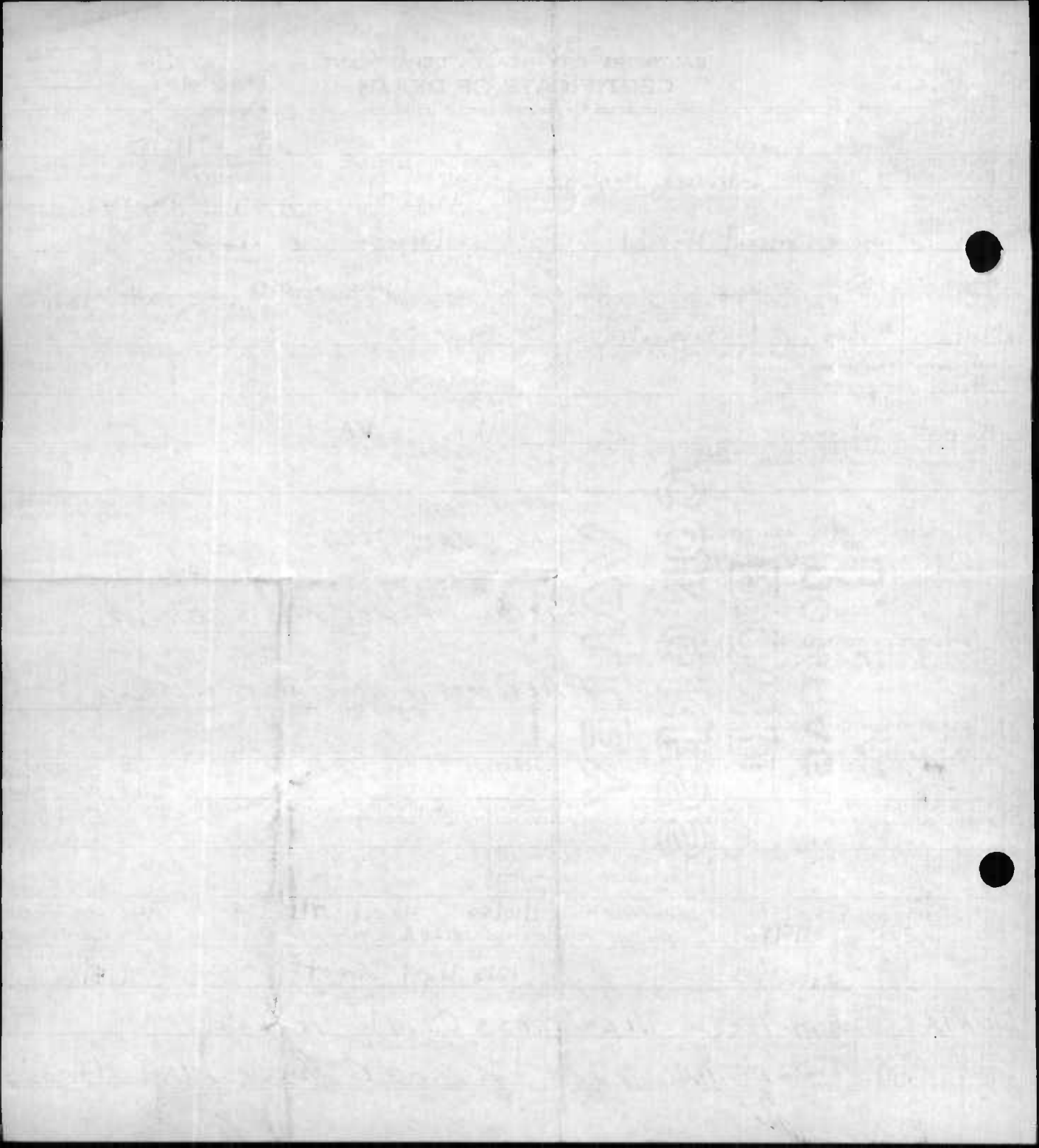
19A. DATE OF OPERATION <u>7/18/50</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/10/50, 1950, to 7/15/50, 1950, that I last saw the deceased alive on 7/15/50, 1950, and that death occurred at 2:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE [Signature] M. D. 1213 Light Street 23B. ADDRESS 7/15/50 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>JULY-18-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CEM</u>	24D. LOCATION (City, town, or county) (State) <u>AA Co.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 17 1950</u>		25. FUNERAL DIRECTOR <u>Thurington Williams, Inc.</u>	ADDRESS <u>Bernard E. Harle 131 E West St</u>

MEDICAL CERTIFICATION



525  
50 6225  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6225  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>NANCY JOHNSON</b>			2. DATE OF DEATH <b>7.14.50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>211 Cantuac Ave.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ind.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>211 Cantuac Ave.</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W.</b>	8. DATE OF BIRTH <b>7.27.1867</b>		9. AGE (In years last birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, on or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Family</b> ADDRESS		

1B. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY Thrombosis</b>	CAUSE OF DEATH (A) <b>CORONARY Thrombosis</b> DUE TO (B) <b>ARTERIOSCLEROTIC Heart Disease</b> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>10 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6-26**, 19**50**, to **7-14**, 19**50**, that I last saw the deceased alive on **7-15**, 19**50**, and that death occurred at **2:50 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Benjamin Sudiansky</b> M. D.	23B. ADDRESS <b>5004 Ritchie Hwy</b>	23C. DATE SIGNED <b>7-17-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B.</b>	24B. DATE <b>7.17.50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Healey</b>	24D. LOCATION (City, town, or county) (State) <b>A.A. Co. - Ind.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>James L. C. C...</b>	ADDRESS <b>130 E. Fair Ave. 93D</b>

Dr. Budweiser  
5000 Ratchet Highway

420  
6226

BLACK

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6226

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Madeline Black

2. DATE  
OF  
DEATH

July 16, 50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Va -

V-43

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Dorchester

D. STREET ADDRESS (If rural, give location)

741 Shirley Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Female White

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

13. FATHER'S NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 194X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Metastases

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

1 MONTH

(over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Carcinoma of thyroid

DUE TO ALSO WITH metastases to Left humerus

2 YEARS

(C) 4th Cervical and 3rd Lumbar VERTEBRA

1 YEAR

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

July 1949

19B. MAJOR FINDINGS OF OPERATION

CARCINOMA of Thyroid

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 25, 1950 to July 16, 1950 that I last saw the deceased alive on July 16, 1950, and that death occurred at 3:18 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Samuel P. Asper Jr. M.D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

July 16, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

7/16/50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Cemetery

24D. LOCATION (City, town, or county)

Norfolk, Va.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

L. H. Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tickner &amp; Sons

Balto. Md. 55c

JUL 17 1950

VS 150

MEDICAL CERTIFICATION

Was it cancer of  
cartilage

or  
gland of thyroid ?

"Cancer of gland of thyroid"

See Document File 50-6226

8-24-50

Es



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6227**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LILLIAN V. LASSAHN</b>			2. DATE OF DEATH <b>July 16th, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. CITY OR TOWN <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>27-04A</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>3814 Echodale Ave.</b>			D. STREET ADDRESS (If rural, give location) <b>3814 Echodale Ave.</b>		
C. Length of stay in Baltimore <b>life</b>			Yrs. Mos. Days		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 27, 1894</b>		9. AGE (In years last birthday) <b>55</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Louis C. Lassahn</b>			14. MOTHER'S MAIDEN NAME <b>Emma Bradley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or unknown) <b>no</b>		16. SOCIAL SECURITY NO.			
17. INFORMANT			ADDRESS		
<b>Mr. Louis C. Lassah</b>			<b>3814 Echodale Ave.</b>		

MEDICAL CERTIFICATION

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b> <b>Coronary sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 Mos</b> <b>?</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>May 27</b> , 1950 to <b>July 16</b> , 1950, that I last saw the deceased alive on <b>7-15</b> , 1950, and that death occurred at <b>8 P.m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <i>Albert E. Singmaster</i>	23B. ADDRESS <b>1613 E. North Ave.</b>	23C. DATE SIGNED <b>7-17-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24B. DATE <b>July 19, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	25. FUNERAL DIRECTOR <i>Lassahn Funeral Home</i>	ADDRESS <b>7401 Belair Rd</b>
VS 150 <b>1613 E North Ave</b>		<b>94a</b>	

10-11-50

10-11-50

10-11-50

10-11-50

10-11-50

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6228  
Registered No.

BIRTH NO. 50 6228 *Harriette*

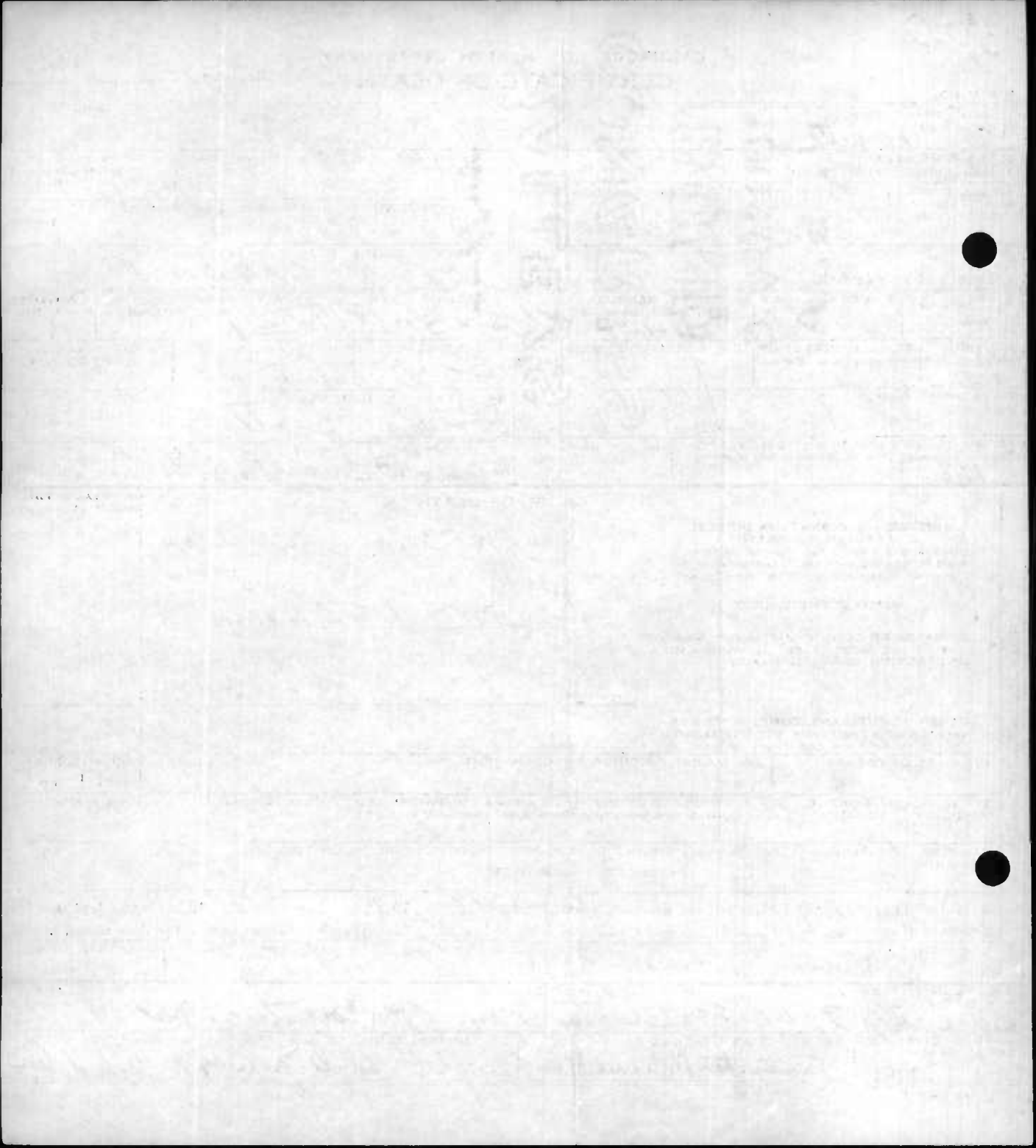
1. NAME OF DECEASED (Type or Print) <i>Harriette HATTIE SCOTT</i>			2. DATE OF DEATH <i>7-13-50</i>		
3. PLACE OF DEATH: a. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>4-02</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSP.</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>BA-TIMORE</i>		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) <i>315 N GREEN ST.</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>COL.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>5-3-1889</i>		9. AGE (In years last birthday) <i>61</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Balts. County, Md</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>?</i>			14. MOTHER'S MAIDEN NAME <i>Louise Scott</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <i>Bessie Fulgham Lewis 315 N. Greene</i>		

MEDICAL CERTIFICATION

18. <i>331X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>CEREBRAL HEMORRHAGE</i> (A) DUE TO			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>HYPER TENSION</i> (B) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19a. DATE OF OPERATION <i>0</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21d. TIME (Month) (Day) (Year) (Hour) INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 12</i> , 19 <i>50</i> , to <i>July 13</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 13</i> , 19 <i>50</i> , and that death occurred at <i>5:00</i> p.m., from the causes and on the date stated above.					
23a. SIGNATURE <i>John W. Stover</i> M. D.		23b. ADDRESS <i>Alma Hoop</i>		23c. DATE SIGNED <i>7-14-50</i>	
24a. BURIAL (CREMATION, REMOVAL) (Specify) <i>Burial</i>	24b. DATE <i>7-17-50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Arbutus Men. Pk</i>	24d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 17 1950</i>	REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>		25. FUNERAL DIRECTOR ADDRESS <i>Joseph B. Lock, Jr 1304 N. Central Ave</i>		

720 8A

83a



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6229  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Lloyd R. Clippinger</b>			2. DATE OF DEATH <b>7-15-50</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>University Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Fowbblesburg,</b>		
c. Length of stay in Baltimore			d. STREET ADDRESS (If rural, give location) <b>5300</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 2, 1905</b>		9. AGE (1n years last birthday) <b>45</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Own</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <b>Clarence Clippinger</b>		
14. MOTHER'S MAIDEN NAME <b>Cora Betz</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <b>Mrs. Jessie E. Clippinger Upperco P.O., Md</b>		

18. <b>E873.4</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Intra Pulmonary Hemorrhage</b> DUE TO <b>multiple fractures of Ribs</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Highway</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Hanover Road</b> <b>5300</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7-15-50</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Auto he was driving ran into a Tree</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>J. B. Fisher</b>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>7-16-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/19/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Dickens</b>		25. FUNERAL DIRECTOR <b>Wm. J. Dickens</b>		ADDRESS <b>Wm. J. Dickens</b>	

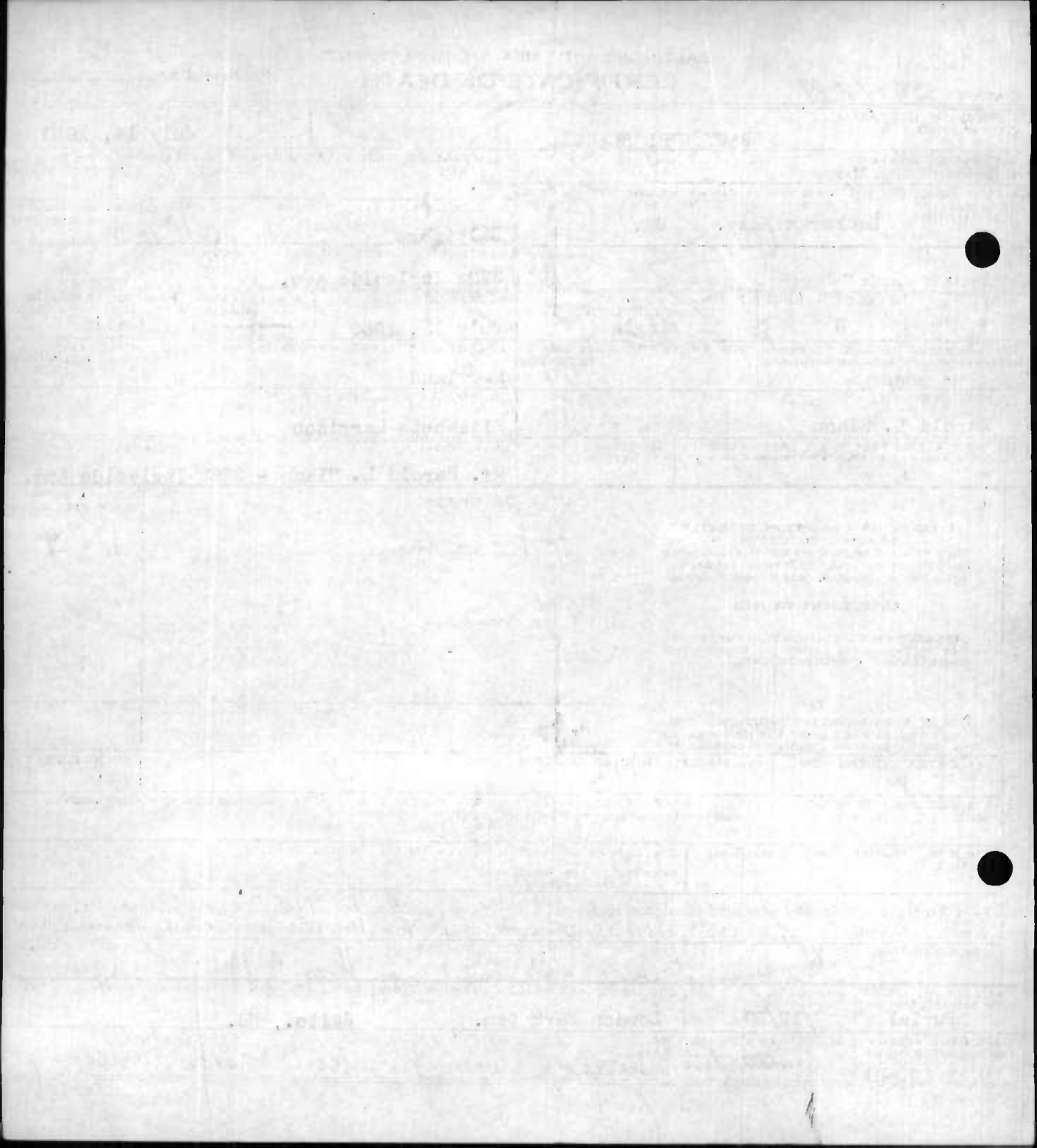
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MEDICAL CERTIFICATION





450 50 6230		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Baby Girl Blann 50 6230 Registered No.	
BIRTH NO. 50-14749				2. DATE OF DEATH July 14, 1950	
1. NAME OF DECEASED (Type or Print) BABY GIRL BLANN				3. PLACE OF DEATH: A. Baltimore City, Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Lutheran Hosp. of Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		5. SEX F	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 3222 Ingleside Ave.		6. COLOR OR RACE W	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single		8. DATE OF BIRTH July 13, 1950		9. AGE (In years last birthday) -----	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harold L. Blann		14. MOTHER'S MAIDEN NAME Elizabeth Harrison		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) -	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Harold L. Blann - 3222 Ingleside Ave.		ADDRESS	
18. 762.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Pneumonia			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION Nov 0		19B. MAJOR FINDINGS OF OPERATION None		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/12, 1950, to 7/14, 1950, that I last saw the deceased alive on 7/14, 1950, and that death occurred at 10:45 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Norman L. ...		23B. ADDRESS Littleton Hosp of Md		23C. DATE SIGNED 7/15/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/17/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) Balto., Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1950		24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
24G. VS 150		24H. FUNERAL DIRECTOR Chas. J. ...		24I. ADDRESS Balto Md.	



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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6231  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE LATROBE EWALT</b>		2. DATE OF DEATH <b>July 14, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2945 St. Paul St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>12-02</b>			
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2945 St. Paul St.</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Apr. 24, 1875</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>physician</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>medical</b>	9. AGE (In years, last birthday) <b>75</b>		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME <b>George Ewalt</b>		14. MOTHER'S MAIDEN NAME <b>Mary Josephine Smith</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT ADDRESS <b>Mr. Geo. L. Ewalt, Jr.</b>	
12. CITIZEN OF WHAT COUNTRY?					

18. <b>334X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <b>Arteriosclerosis (Cerebral)</b>		DUE TO		<b>3 years</b>	
ANTECEDENT CAUSES		(B) <b>Arteriosclerosis (Generalized)</b>		<b>5 years</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO			
II		(C) ...			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 15, 1948**, to **July 14, 1950**, that I last saw the deceased alive on **July 13, 1950**, and that death occurred at **5:40 A.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>W. Grafton Hensperger</b>		23B. ADDRESS <b>214 Medical Arts Building</b>		23C. DATE SIGNED <b>7/14/50</b>	
M. D.					

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/17/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Tichenor &amp; Sons - Baltimore, Md.</b>		ADDRESS	
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VALLEY

W. CONIGRUE

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>BERNICE COLLOM ZWEIER</b>		2. DATE OF DEATH <b>July 14, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1203 Windemere Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>1203 Windemere Ave.</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 21, 1908</b>	9. AGE (In years last birthday) <b>42</b>	10. Under 1 Year Months: _____ Days: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? _____		13. FATHER'S NAME <b>Clement Collom</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT ADDRESS <b>Mr. Ralph D. Zweier 1203 Windemere Ave</b>	

18. <b>170X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Caused by Carcinoma of breast</b> DUE TO (A) _____ DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1949</b> <b>1948</b>	CAUSE OF DEATH <b>Generalized Carcinoma of breast</b> <b>Carcinoma of breast</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____	

19A. DATE OF OPERATION <b>1949</b>	19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma Breast &amp; Cervix</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____
22. I hereby certify that I attended the deceased from <b>1946</b> , 19 <b>50</b> , to <b>7/14</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/13</b> , 19 <b>50</b> , and that death occurred at <b>11:19</b> a. m., from the causes and on the date stated above.		
23A. SIGNATURE <b>Walter E. Rogers</b>		23B. ADDRESS <b>4331 Harford Rd</b>
23C. DATE SIGNED <b>7/15/50</b>		24. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/17/50</b>	24C. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>Thos. J. Tichener &amp; Sons - Balto. Md.</b>

VALLEY  
CONGRES  
COMAND  
J. E.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 6233

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>MARY EMMA PERVEIL</b>		2. DATE OF DEATH <b>July 15, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <b>Home for the Aged of the Methodist</b> <b>2211 W. Rogers Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>27-15</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>2211 W. Rogers Ave.</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Jan. 6, 1858</b> <b>92</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never worked</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>92</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Henry Perveil</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hamell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Miss Mamie B. Fisher</b>		ADDRESS <b>2211 W. Rogers Ave.</b>	

18. <b>4 yr. 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial insufficiency</b> DUE TO <b>Arteriosclerosis</b> DUE TO <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>20 yrs.</b>
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19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct 15, 1949</b> , to <b>July 15, 1950</b> , that I last saw the deceased alive on <b>July 15, 1950</b> , and that death occurred at <b>9:15 P. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Arthur J. Dames</b> M. D.		23B. ADDRESS <b>800 W 33rd St</b>		23C. DATE SIGNED <b>7-16-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/18/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Wesley M.E. Ch. Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Davidsonville, Md.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Dickner &amp; Sons - Realty</b> ADDRESS _____			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Christina Williams, M.D.</b>			

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CERTIFICATE OF DEATH

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6234  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Charles Banks Orrell</i>		2. DATE OF DEATH <i>July 15, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>406 Ilchester Ave.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md</i> B. COUNTY <i>Balto</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>12-03</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>406 Ilchester Ave</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct 4, 1868</i>
10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <i>Clerical</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>	9. AGE (in years last birthday) <i>81</i>
13. FATHER'S NAME <i>Adolphus Lafayette Orrell</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		17. INFORMANT <i>Miss Anna J. Orrell, Ilchester Ave</i>	
16. SOCIAL SECURITY NO.		ADDRESS <i>406 Ilchester Ave</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>450.11 177X</i> Arteriosclerotic gangrene - amputation of both legs		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) <i>Arteriosclerosis, generalized</i> (B) <i>Semility</i> (C)		<i>10 yrs.</i> <i>10 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Carcinoma of Prostate</i>		<i>1 yr.</i>	
19A. DATE OF OPERATION <i>Feb. 10, 1949</i> <i>March 27, 1950</i>		19B. MAJOR FINDINGS OF OPERATION - <i>Arteriosclerotic gangrene - amputation of both legs.</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 10, 1949</i> to <i>July 15, 1950</i> that I last saw the deceased alive on <i>July 7, 1950</i> and that death occurred at <i>10 p.m.</i> , from the causes and on the date stated above.			
23A. SIGNATURE <i>A. S. Chaffert</i>		23B. ADDRESS <i>6210 York Road</i>	
23C. DATE SIGNED <i>July 17, 1950</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Reburial</i>		24B. DATE <i>July 19, 1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Balto</i>		24D. LOCATION (City, town, or county) (State) <i>North Ave - Balto Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 17 1950</i>		25. FUNERAL DIRECTOR <i>W. H. Archer, Benoni Md</i>	
REGISTRAR'S SIGNATURE <i>Wilmington Williams, Md</i>		ADDRESS	

MEDICAL CERTIFICATION

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is mostly mirrored and difficult to decipher.]*

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6235

BIRTH NO. 6235

1. NAME OF DECEASED (Type or Print) <b>RUBY JULIA WEEKS</b>			2. DATE OF DEATH <b>JULY 16, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3201 BAYONE AVE.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTO 27-04B.</b>		
c. Length of stay in Baltimore <b>15 Yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>3201 BAYONE AVE.</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>MAY 16, 1911</b>		9. AGE (in years last birthday) <b>39</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>CHARLES B. WEEKS</b>			14. MOTHER'S MAIDEN NAME <b>ROSALLIE TAYLOR</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>MRS. ANN PROTASOSS SAME</b>		

18. <b>171X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Generalized carcinomatosis</b> DUE TO (B) <b>Ca of cervix</b> DUE TO (C) <b>-</b>	INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>  <b>3 years!</b>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1945</b> , 19__, to <b>July 16, 1950</b> that I last saw the deceased alive on <b>July 1, 1950</b> , and that death occurred at <b>10 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>H.W. Jenkins</b>		23B. ADDRESS M. D. <b>3921 Edgemoor Ave.</b>		23C. DATE SIGNED <b>7/16/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JULY 19, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>PINE VIEW</b>	
				24D. LOCATION (City, town, or county) (State) <b>Rocky Mount N.C.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>H.W. JENKINS &amp; SONS Co. 4905 YORK RD.</b>	

DR H W SCHEVE

3921 EDMONDSON

525 NORMANDY



236  
6236Shoes BRAND  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6236

1. NAME OF DECEASED (Type or Print) <u>Isabella Shostrand</u>		2. DATE OF DEATH <u>7/15/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>27-10</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>Union Memorial Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Balto 17d</u>	
C. Length of stay in Baltimore <u>10</u> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <u>5116 Craig Ave</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Jan 20, 1883</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>67</u> If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
13. FATHER'S NAME <u>Donald Shaw Fraser</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
17. INFORMANT <u>DONALD SCHOESTRAND</u>		ADDRESS <u>SAME</u>	

18. 443X CAUSE OF DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
(A) Hypertensive Arteriosclerotic C.U. disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) .....  
DUE TO

(C) .....

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inspection thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE [Signature] M.D. 23B. CHIEF MEDICAL EXAMINER.....  
23C. DATE SIGNED 7/16/50  
ASSISTANT MEDICAL EXAMINER.....

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7-18-1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LODOW PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 17 1950</u>		REGISTRAR'S SIGNATURE <u>Thurston Williams, Jr.</u>		25. FUNERAL DIRECTOR <u>H.W. JENKINS &amp; Sons Co.</u>		ADDRESS <u>4905 York Rd</u>	

93D ✓

STATE OF TEXAS

201

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50 6237

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6237

BIRTH NO. 50-12796

1. NAME OF DECEASED (Type or Print) Baby Girl Love			2. DATE OF DEATH June 24, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-32		
B. FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (Cherry Hill)		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 3000 3000 Seamon Avenue		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June 24, 1950		9. AGE (In years last birthday) 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? 1
13. FATHER'S NAME Nathaniel Love			14. MOTHER'S MAIDEN NAME Myrtle Edwards		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Hospital Records		

## 18. 757.1 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anemia

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Complete destruction of Renal tissue due to Polycystic Kidneys

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 24, 1950, to June 24, 1950, that I last saw the deceased alive on June 24, 1950, and that death occurred at 12:10 P.M., from the causes and on the date stated above.					
23A. SIGNATURE E. E. Flowers Jr.		23B. ADDRESS 601 N. Broadway		23C. DATE SIGNED 6-28-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY Hospital Disposal	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	

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50 6238

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6238

BIRTH NO. 50-13555

1. NAME OF DECEASED  
(Type or Print)

Baby Boy Genter (Leidalia)

2. DATE  
OF  
DEATH July 1, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

Pennsylvania

B. COUNTY

C. CITY OR TOWN

Saratoga Saranton

D. STREET ADDRESS (If rural, give location)

1012 Clay Street

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

July 1, 1950

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

30

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Infant

10B. KIND OF BUSINESS OR  
INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James A. Genter

14. MOTHER'S MAIDEN NAME

Leidalia Jimenez Calderon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Records

18. 776X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Prematurity

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

30 min

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1950, to July 1, 1950 that I last saw the  
deceased alive on July 1, 1950, and that death occurred at 12:30 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. D.

601 N. Broadway

July 5, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 17 1950

Huntington Williams, M.D.

VS 150

30 min 2 3 7

159

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MINISTRY OF HEALTH

NO. 101

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

III

DATE OF DEATH

DATE OF BIRTH

DATE OF DEATH



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6239

Registered No. \_\_\_\_\_

200  
0 6239

1. NAME OF DECEASED (Type or Print) <b>WALTER CZAJA or CZAJA</b>				2. DATE OF DEATH <b>JULY 15-1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>535 N. KENWOOD AVE</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>HOME</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 7-01</b>			
C. Length of stay in Baltimore <b>46 YRS</b>				D. STREET ADDRESS (If rural, give location) <b>535 N. KENWOOD AVE</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>JAN-10-1897</b>	9. AGE (In years last birthday) <b>53</b>	10. Under 1 Year Months: _____ Days: _____	11. Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>WARDS BAKERY</b>		12. CITIZEN OF WHAT COUNTRY? <b>POLAND</b>	
13. FATHER'S NAME <b>CAROL CZAJA</b>				14. MOTHER'S MAIDEN NAME <b>MARYANN STEFAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknowns)		16. SOCIAL SECURITY NO. <b>213-01-4299</b>		17. INFORMANT ADDRESS <b>Mrs Anna Czaja 535 N. Kenwood</b>			
18. <b>002 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Embolism</b>				CAUSE OF DEATH (A) <b>Pulmonary Embolism</b> DUE TO (B) <b>Phlebotomies</b> DUE TO (C) <b>Pulmonary Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>3 weeks</b> <b>7 mos.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>None</b>				19B. MAJOR FINDINGS OF OPERATION <b>None</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7-14-1950</b> to <b>7-15-1950</b> that I last saw the deceased alive on <b>7-15-1950</b> and that death occurred at <b>11:15 A.m.</b> , from the causes and on the date stated above.							
23A. SIGNATURE <b>George A. Weber</b>				23B. ADDRESS <b>715 N. Charles St.</b>		23C. DATE SIGNED <b>7-15-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JULY 18-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE CO. MD.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 S. Penn St</b>	

MEDICAL CERTIFICATION

554 44 38 13B

30 7 83  
[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "CASA", "HALL", and "STREET" are faintly visible.]

563  
6240

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

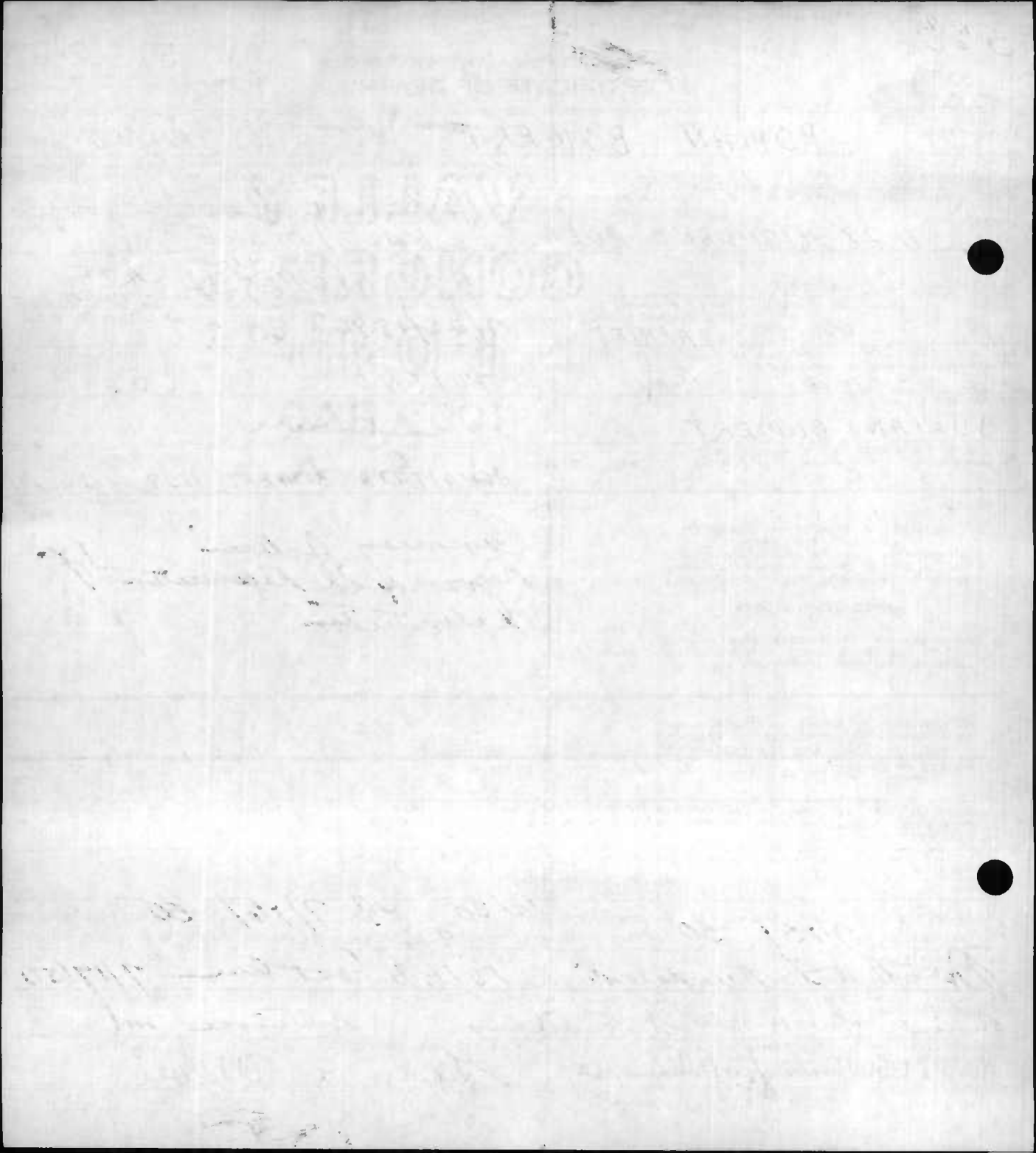
50 6240

Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ROMAN BOMERT</b>		2. DATE OF DEATH <b>7/16/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>HOME</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>26-11</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1128 HIGHLAND AVE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1128 HIGHLAND AVE</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7/25/1886?</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	9. AGE (in years last birthday) <b>63?</b>
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JULIAN BOMERT</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HENRIETTA BOMERT</b>		ADDRESS <b>1128 Highland Ave</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Artery Hypertrophic Degeneration of Myocardium</b> CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6/30</b> , 19 <b>49</b> , to <b>7/16</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7/15</b> , 19 <b>50</b> , and that death occurred at <b>4 P. m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Dr. Edward J. Lukowski</b>		23B. ADDRESS <b>1016 E East Ave</b>	
23C. DATE SIGNED <b>7/17/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 18-1950</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, MD</b>	
25. FUNERAL DIRECTOR <b>George A Weber</b>		ADDRESS	

MEDICAL CERTIFICATION

82010239 93D



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6241

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*William G. Hockensmith, 538963*

2. DATE  
OF  
DEATH

*July 14, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Md.* B. COUNTY *Anne Arundel*

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
*JOHNS HOPKINS HOSPITAL*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Millersville*

D. STREET ADDRESS (If rural, give location)  
*CHAIN HWY. 5200*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*male*

6. COLOR OR RACE

*white*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*M.*

8. DATE OF BIRTH

*7-28-03*

9. AGE (In years last birthday)

*46*

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*P. B. X. Repairman*

10B. KIND OF BUSINESS OR INDUSTRY

*Telephone*

11. BIRTHPLACE (State or foreign country)

*Pennsylvania*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Calvin H. Hockensmith*

14. MOTHER'S MAIDEN NAME

*Ella W. McClure*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
*no*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*JOHNS HOPKINS HOSPITAL*

18. *443X*

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

*Hypertensive and Arterio-sclerotic Cardio-Vascular Disease*

(B)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

INTERVAL BETWEEN ONSET AND DEATH

*years*

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Obesity due to Excess Food*

*years*

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *6-14-1950* to *7-14-1950*, that I last saw the deceased alive on *7-14-1950*, and that death occurred at *11:53 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE

*David Lukens*

M. D.

23B. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED

*7-15-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*Burial*

24B. DATE

*7/18/50*

24C. NAME OF CEMETERY OR CREMATORY

*Moreland Mem. Pk.*

24D. LOCATION (City, town, or county) (State)

*Taylor Ave.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

*Thm. J. Pickens & Son, Balt Md*

ADDRESS

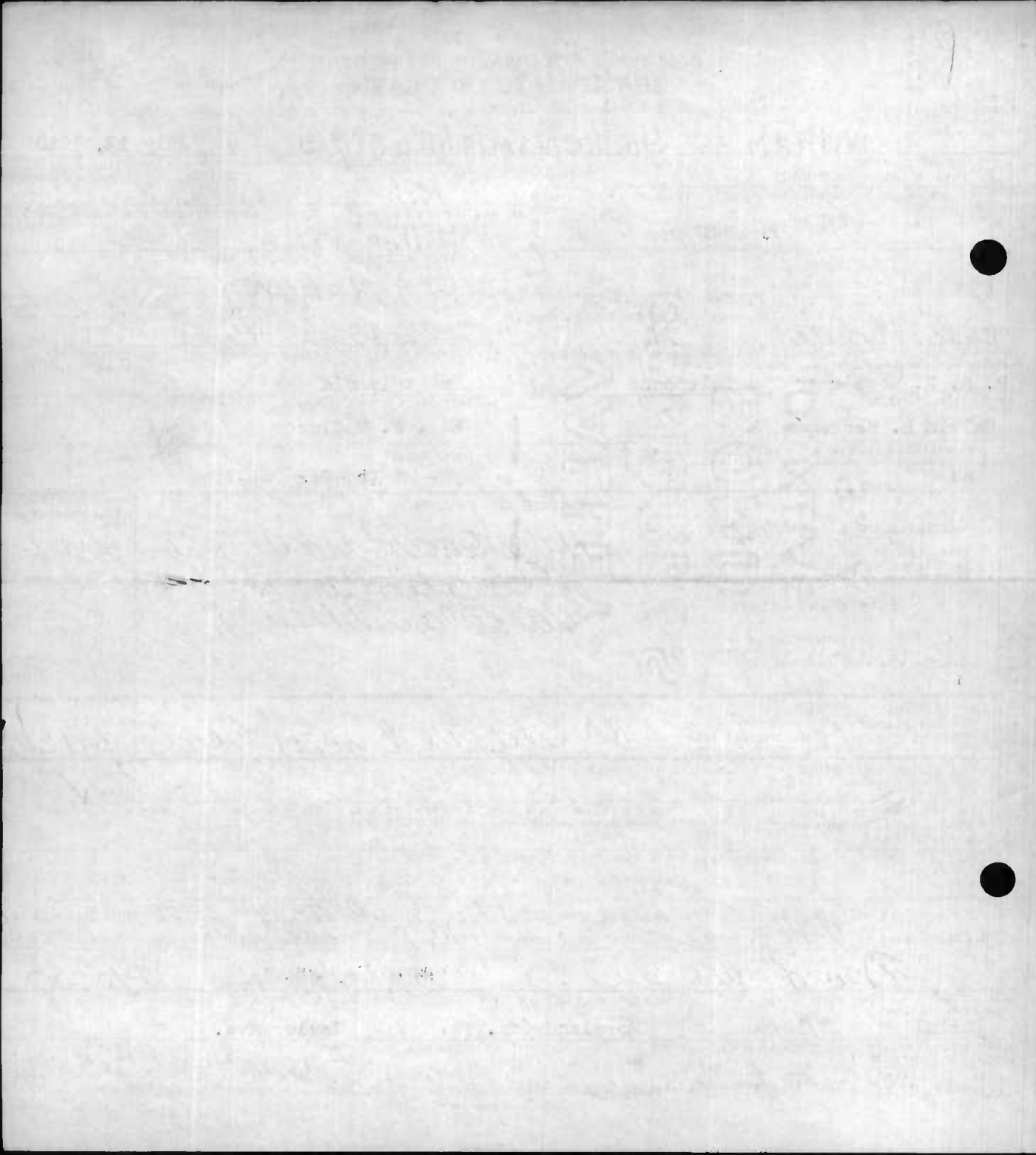
JUL 17 1950

VS 150

*540 5A.*

*93D*

MEDICAL CERTIFICATION





53 Med. Exam. Case Released To Hospital

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6242

BIRTH NO. 50 6242

1. NAME OF DECEASED (Type or Print) <b>IRVIN GEORGE BARNETT</b>			2. DATE OF DEATH <b>JUL 15 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, 12-02</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>300 E. 30th St.</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/25/1894</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>			11. BIRTHPLACE (State or foreign country) <b>Roxboro, N.C.</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Apt. House</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Nate Barnett</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Obrien</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>171-10-6189</b>		
17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>			ADDRESS		

MEDICAL CERTIFICATION

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>	CAUSE OF DEATH (A) <b>Myocardial infarction</b> DUE TO (B) <b>Coronary arteriosclerosis</b> DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7-15-1950</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-15-1950** to **7-15-1950**, that I last saw the deceased alive on **7-15-1950**, and that death occurred at **11:10 P.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Joseph Stokes Jr.</b>	23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	23C. DATE SIGNED
--	---	------------------

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/19/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Haven Memorial</b>	24D. LOCATION (City, town, or county) (State) <b>Chester, Pa.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Chas. J. Curran</b>	ADDRESS <b>512 N. Carrollton Ave</b>
--	---	--	---

VS 150

To be Approved by Medical Examiner.

94a

NOT A MEDICAL EXAMINER'S CASE

*R. S. Fisher*

M.D.

CHIEF OR ASST. MEDICAL EXAMINER

260  
50 6243

50 6243

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

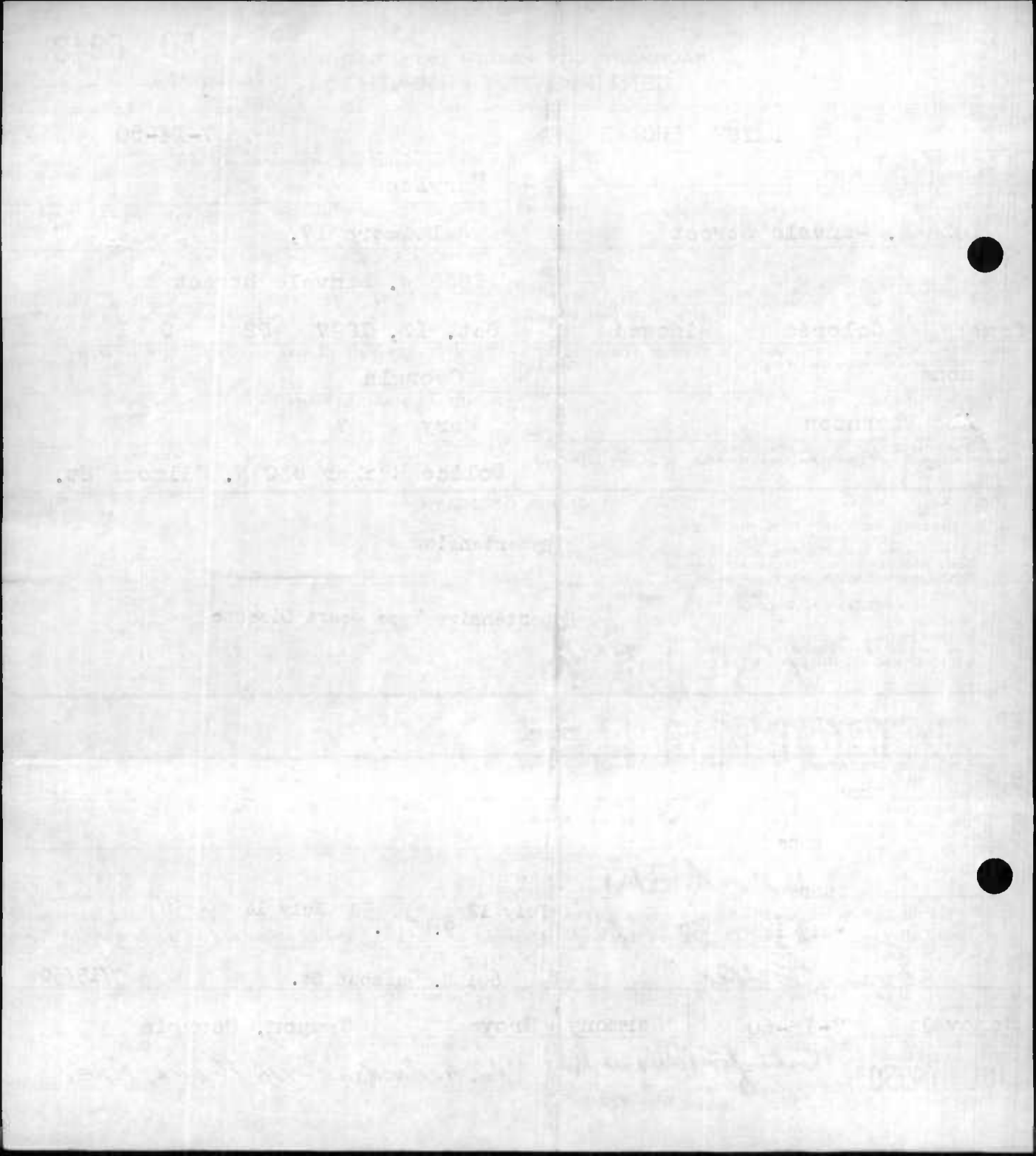
Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>DAISY RUCKER</b>		2. DATE OF DEATH <b>7-14-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>1638 W. Lanvale Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 17, 16-03</b>		
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>1638 W. Lanvale Street</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		B. DATE OF BIRTH <b>Oct. 13, 1897</b>	9. AGE (in years last birthday) <b>52</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	12. CITIZEN OF WHAT COUNTRY? _____
13. FATHER'S NAME <b>Abe Thornton</b>			14. MOTHER'S MAIDEN NAME <b>Mary ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <b>Dolice Rucker 630 N. Gilmore St.</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertension</b> DUE TO _____  ANTECEDENT CAUSES <b>Hypertensive Type Heart Disease</b> DUE TO _____  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>none</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <b>none</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>none</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 12</b> , 19 <b>50</b> , <b>July 14</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 14</b> , 19 <b>50</b> and that death occurred at <b>9:45 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Evans Bikes</b>		23B. ADDRESS <b>601 N. Calhoun St.</b>		23C. DATE SIGNED <b>7/15/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>7-16-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Harmony Grove</b>	
24D. LOCATION (City, town, or county) (State) <b>Cannon, Georgia</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. A. JACKSON-916 PENNA. AVE.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, MD</b>			

MEDICAL CERTIFICATION

1-25000006242

93D



200

50 6244

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

6244  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY MEISE</b>		2. DATE OF DEATH <b>7/15/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTO.</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1803 N. PATTERSON PARK AVE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>July 30<sup>th</sup> 1885</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lease Stacker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Globe Brewery</b>	9. AGE (In years last birthday) Months Days <b>64</b>
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Andrew Meise</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Emma Meise</b>		ADDRESS <b>Park Ave 1803 N. Patterson</b>	

18. **443 X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) **Cerebral hemorrhage**  
DUE TO **hypertensive - arterio-sclerotic cardio-vascular disease**  
(B)  
DUE TO  
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/15/50</b> , to <b>7/15/50</b> , that I last saw the deceased alive on <b>7/15/50</b> , and that death occurred at <b>8<sup>45</sup> m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Macdusa Siwinski</b> M. D.		23B. ADDRESS <b>St. Joseph's Hosp.</b>		23C. DATE SIGNED <b>7/15/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 18<sup>th</sup> 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>	
24D. LOCATION (City, town, or county) (State) <b>Greenmount &amp; Oliver Sts</b>		25. FUNERAL DIRECTOR <b>Leo S. Leach</b> ADDRESS <b>1703 N. Patterson Park Ave</b>			

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

JUL 17 1950

**Wilmington Williams, M.D.**

VS 150

97046243

937

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

5/15/77

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

[illegible text follows]



Medical Examiner's Case

Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6245  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Waisy Linchberg</i>		2. DATE OF DEATH <i>July 14 50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balti. City</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ind.</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
5. Length of stay in Baltimore <i>25 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>1153 E. Lombard St</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>10-31-90</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (in years last birthday) <i>59 yrs</i>
13. FATHER'S NAME <i>Hughes Camp</i>		11. BIRTHPLACE (State or foreign country) <i>Gaston N.C.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) <i>no</i>		14. MOTHER'S MAIDEN NAME <i>Miss Camp</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>E 916.01</i> <i>First, Second, and Third degree burns of body</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive cardiovascular disease with terminal uremia</i>		CERTIFICATION APPROVED BY <i>Dr. C. J. Lubinski</i> per <i>R. B. Fisher</i> M.D. CHIEF OR AGENT MEDICAL EXAMINER
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<i>2 yrs</i>

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>	21C. WHERE DID INJURY OCCUR? <i>1153 E. Lombard St.</i>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>7-7-50</i>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <i>Walked into candle clothes caught on fire</i>		
22. I hereby certify that I attended the deceased from <i>July 8, 1950</i> to <i>July 14, 1950</i> , that I last saw the deceased alive on <i>July 14, 1950</i> and that death occurred at <i>m.</i> , from the causes and on the date stated above.				
23A. SIGNATURE <i>William F. Riehlf III</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>7-14-50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>7-17-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>McCalvery Arm.</i>	24D. LOCATION (City, town, or county) (State) <i>Brooklyn, Ind</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 17 1950</i>		25. FUNERAL DIRECTOR <i>Chas. Wilson 1000 Beattysville</i>		

VS 150 N-948.2  
Certificates to be approved by Medical Examiner

1852-53  
1854-55

5-41-7

1000

1. 1. 1. 1. 1. 1.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6246**

**200**  
**6246**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RIDA COOK</b>		2. DATE OF DEATH <b>7/16/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>22</b>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>818 WILLIAM ST.</b>		C. CITY OR TOWN (If outside corporate limits write RURAL and give township) <b>BALTIMORE</b>	
6. Length of stay in Baltimore Yrs. <b>0</b> Mos. <b>0</b> Days <b>0</b>		D. STREET ADDRESS (If rural, give location) <b>818 WILLIAM ST.</b>	
7. SEX <b>F</b>	8. COLOR OR RACE <b>W</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	10. DATE OF BIRTH <b>FEB 28, 1866</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		12. AGE (In years last birthday) <b>84</b>	
13. FATHER'S NAME <b>JOSEPH H. WINGATE</b>		14. BIRTHPLACE (State or foreign country) <b>WINGATE'S, MD.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. CITIZEN OF WHAT COUNTRY? <b>LAURA FALLON</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>MR. OLIN COOK 818 WILLIAM ST</b>	

18. <b>442X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Heart failure</b> DUE TO <b>Hypertension and atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>corebral sclerosis</b> DUE TO		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 5, 1950</b> to <b>July 16, 1950</b> , that I last saw the deceased alive on <b>July 16, 1950</b> and that death occurred at <b>2:53 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Samuel Rubin</b> M. D.		23B. ADDRESS <b>203 Delaplace</b>		23C. DATE SIGNED <b>7/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/19/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LODOW PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>FREDERICK ROAD</b>		25. FUNERAL DIRECTOR ADDRESS <b>JOHN F. DENNY, INC 715 LIGHT ST 30</b>			

Mr. Samuel Rubin  
203 Palomar Ave

650  
6247 J1-139567  
50-15797

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6247  
Registered No.

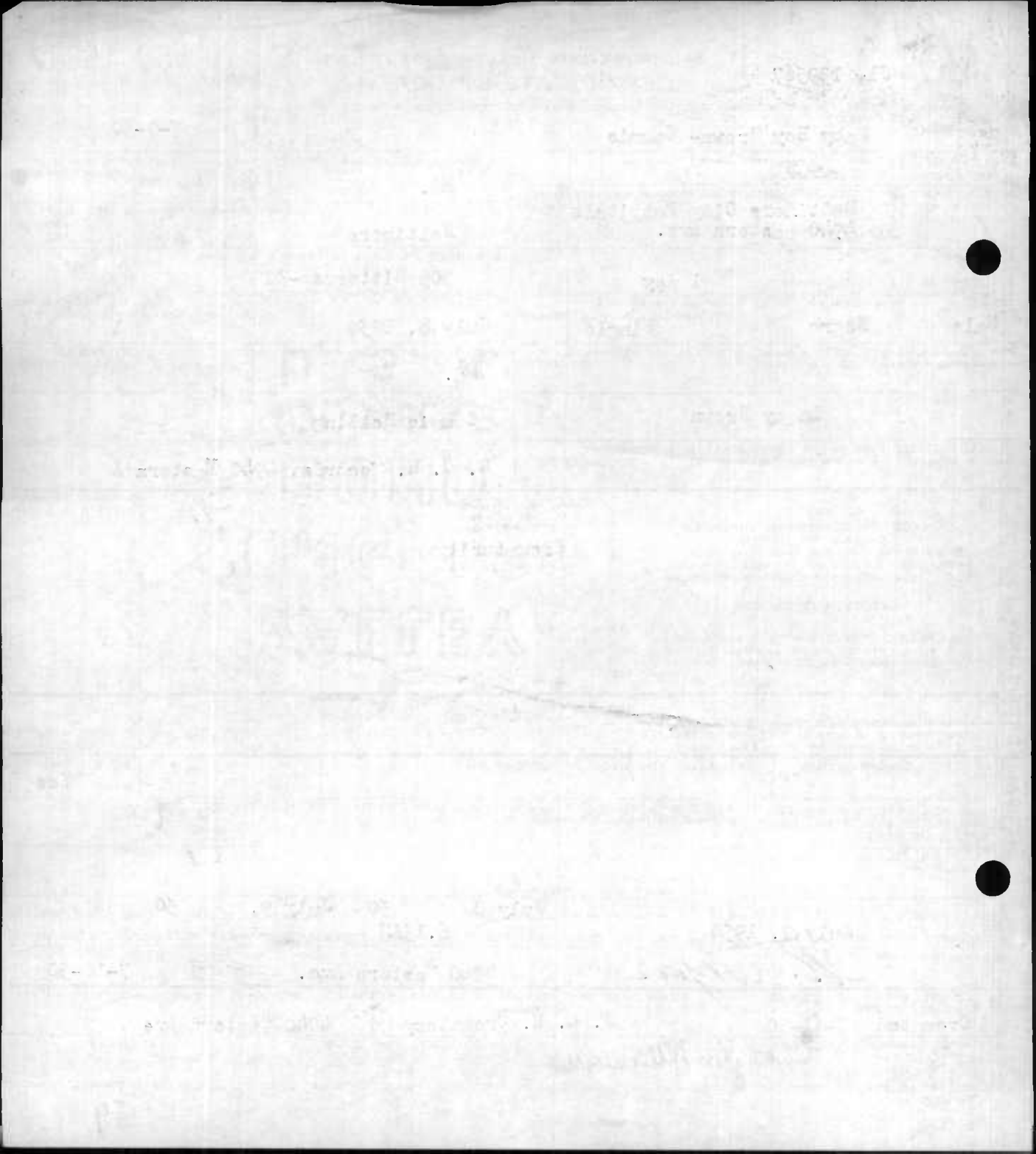
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Brown- Cammie</b>		2. DATE OF DEATH <b>7-9-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>Dundalk</b>	
c. Length of stay in Baltimore <b>1 day</b>		D. STREET ADDRESS (If rural, give location) <b>303 Bitterns -22</b> <b>5200</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>July 8, 1950</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>La cy Brown</b>		14. MOTHER'S MAIDEN NAME <b>Cammie Bolling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>B. C. H. Records, 4940 Eastern Ave</b>		ADDRESS	

18. <b>776 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Prematurity</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <b>Prematurity</b>	INTERVAL BETWEEN ONSET AND DEATH
--	--------------------------------------	----------------------------------

19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 8, 1950</b> , to <b>July 9, 1950</b> , that I last saw the deceased alive on <b>July 9, 1950</b> and that death occurred at <b>6.15AM</b> , from the causes and on the date stated above.					
23A. SIGNATURE <i>H. Brown</i>		23B. ADDRESS <b>4940 Eastern Ave.</b>		23C. DATE SIGNED <b>7-10-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>		24B. DATE <b>7-11-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>B. C. H. Crematory</b>	
24D. LOCATION (City, town, or county) (State) <b>4940 Eastern Ave.</b>		25. FUNERAL DIRECTOR <b>William Williams, M.D.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		VS 150			

MEDICAL CERTIFICATION

6246 159





456	Fillmore	50 6248	50 6248
BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Fillmore, Romaine		2. DATE OF DEATH 17 July 50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pa B. COUNTY York	
B. FULL NAME OF HOSPITAL OR INSTITUTION 3 University Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) York V-35	
c. Length of stay in Baltimore 5 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 306 S. George St.	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 1901
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) York Pa
13. FATHER'S NAME Harry Fultz		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Nettie Trump
18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES		INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) Intracerebral + Subarachnoid Hemorrhage 9 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(B) Ruptured Aneurysm Circle of Willis	
II		(C) Hypertensive CVD	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 13 July, 1950, to 17 July, 1950, that I last saw the deceased alive on 16 July, 1950, and that death occurred at 12 <sup>00</sup> Am., from the causes and on the date stated above.			
23A. SIGNATURE Roy B. Turner		23B. ADDRESS University Hospital	
23C. DATE SIGNED 17 July 50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE July 20, 1950	
24C. NAME OF CEMETERY OR CREMATORY Mount Rose Cemetery		24D. LOCATION (City, town, or county) (State) York, Pa.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 17 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
25. FUNERAL DIRECTOR Wm. Cook Inc. 1217 St. Paul St.		ADDRESS	
VS 150			

STATE OF OHIO

IN SENATE

January 1, 1900

REPORT

OF THE

COMMISSIONER OF THE

LAND OFFICE

TO THE

LEGISLATURE

OF THE

STATE OF OHIO

FOR THE

YEAR 1899

AND

THE FIRST

SESSION OF THE

LEGISLATURE

OF THE

STATE OF OHIO

IN 1900

AND

THE

SECOND

SESSION OF THE

LEGISLATURE

OF THE

STATE OF OHIO

IN 1900

AND

THE

THIRD

SESSION OF THE

LEGISLATURE

OF THE

STATE OF OHIO

IN 1900

AND

THE

FOURTH

SESSION OF THE

LEGISLATURE

OF THE

STATE OF OHIO

IN 1900

AND

THE

FIFTH

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6249**

1. NAME OF DECEASED (Type or Print) <b>HARRY WESSEL</b>		2. DATE OF DEATH <b>July 14, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Carney</b>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>E. Joppa Road</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 5-1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Edge Setter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Swann Shoe Co.</b>	9. AGE (In years last birthday) <b>61</b>
13. FATHER'S NAME <b>?</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia Pa.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>?</b>	
17. INFORMANT <b>Mrs. Charlotte Wessel</b>		ADDRESS <b>E. Joppa Rd</b>	

18. <b>CAUSE OF DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23a. SIGNATURE <b>[Signature]</b>		23b. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23c. DATE SIGNED <b>July 15, 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7-18-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24d. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>L. J. Luck</b>		ADDRESS <b>5305 Harford Rd</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md</b>		69004W	

MEDICAL CERTIFICATION

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that

JOHN A. SMITH, of the County of Dallas, State of Texas,

do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the County of Dallas, State of Texas.

Witness my hand and seal of office this 1st day of January, 1901.

JOHN A. SMITH, County Clerk.

My commission expires this 1st day of January, 1902.

JOHN A. SMITH, County Clerk.

My commission expires this 1st day of January, 1902.

JOHN A. SMITH, County Clerk.

My commission expires this 1st day of January, 1902.

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JOHN A. SMITH, County Clerk.

My commission expires this 1st day of January, 1902.

JOHN A. SMITH, County Clerk.

120 6250

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6250

BIRTH NO. 6250

1. NAME OF DECEASED (Type or Print) *HARRY A. DAVIS*

2. DATE OF DEATH *7/17/50*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE *MD* B. COUNTY *BALTIMORE*

5. SEX *Male* 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *MARRIED*

8. DATE OF BIRTH *9/27/1878* 9. AGE (In years last birthday) *71* 10. UNDER 1 Year Months: Days 11. UNDER 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *RETIRED* 11. BIRTHPLACE (State or foreign country) *MARYLAND* 12. CITIZEN OF WHAT COUNTRY? *U.S.*

13. FATHER'S NAME *ARCHIBALD DAVIS* 14. MOTHER'S MAIDEN NAME *MARY HEINES*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 16. SOCIAL SECURITY NO. *MISS. GERTRUDE DAVIS 26 Willow*

17. INFORMANT ADDRESS *MISS. GERTRUDE DAVIS 26 Willow*

18. *420.1* I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH  
(A) *Coronary Thrombosis* 16 hrs  
DUE TO  
(B) *Arteriosclerosis*  
DUE TO  
(C) *Renal Failure*

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0* 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7/15*, 19*50*, to *7/17*, 19*50*, that I last saw the deceased alive on *7/17*, 19*50*, and that death occurred at *3:30* p. m., from the causes and on the date stated above.

23A. SIGNATURE *John E. Healy* M. D. 23B. ADDRESS *St. Agnes Hosp* 23C. DATE SIGNED *7/17/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *7-20-50* 24C. NAME OF CEMETERY OR CREMATORY *THE Maria* 24D. LOCATION (City, town, or county) *Towson Md* (State)

DATE RECEIVED BY LOCAL REGISTRAR *JUL 17 1950* REGISTRAR'S SIGNATURE *Thurston Williams, M.D.* 25. FUNERAL DIRECTOR *L. J. Luck* ADDRESS *5305 Bayford Rd*

VS 150 38058 94a

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM FOR THE DIRECTOR

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

DATE: [REDACTED]

CLASSIFICATION: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

9. [REDACTED]

10. [REDACTED]

11. [REDACTED]

12. [REDACTED]

13. [REDACTED]

14. [REDACTED]

15. [REDACTED]

16. [REDACTED]

17. [REDACTED]

18. [REDACTED]

19. [REDACTED]

20. [REDACTED]

21. [REDACTED]

22. [REDACTED]

23. [REDACTED]

24. [REDACTED]



200  
50 6251BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6251

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Mary Bowes

2. DATE  
OF  
DEATH

7/15/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

Lutheran Hospital of Baltimore Md.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

LUKE McCUSKER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

8. DATE OF BIRTH

Sept. 12, 1904

9. AGE (In years, last birthday)

45 4/6

11 Under 1 Year Months: Days

11 Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Delia Fleming

17. INFORMANT

Hospital Record

ADDRESS

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Decompensation c. cong. heart failure

15 years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Heart Disease

DUE TO

(C) Uremia, Chronic glomerulonephritis

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia, Hypertension

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1950, to July 15, 1950, that I last saw the deceased alive on July 15, 1950, and that death occurred at 1:15 p. m., from the causes and on the date stated above.

23A. SIGNATURE

John C. Bizer

M. D.

23B. ADDRESS

Lutheran Hospitals Md

23C. DATE SIGNED

7-15-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/19/50

24C. NAME OF CEMETERY OR CREMATORY

New Catholic Cem

24D. LOCATION (City, town, or county)

Baltimore Md

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Charles H. Evans &amp; Son Inc

ADDRESS

118 W. Mt Royal Ave. 131a

Section 22

John T. King

1. Mr. McE. 2. Mrs.

13th Nov 1890  
The Catholic Church  
Baltimore Md  
Charles F. ...  
115 W. ...

424

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6252

BIRTH NO. 6252

1. NAME OF DECEASED  
(Type or Print)

EMMA M. SCHLEGEL

2. DATE  
OF  
DEATH

July 16, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Union Memorial Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore - St. Paul Court Apt. 204B

D. STREET ADDRESS (If rural, give location)

32nd &amp; St. Paul Streets

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Mar. 6, 1880

9. AGE (In years  
last birthday)

70

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

never worked

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Andrew Schlegel

14. MOTHER'S MAIDEN NAME

Amelia Bockelman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

no

17. INFORMANT

ADDRESS

Mr. Jacob Bockelman - 5216 Tramore Rd.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO  
(C)II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

Stanley B. Guisardier M.D.

23B. CHIEF MEDICAL EXAMINER.....☐  
ASSISTANT MEDICAL EXAMINER.....☒  
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

July 17, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/18/50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

J. M. J. Schuer + Sons Balto Md.

ADDRESS

93D

STATE OF OHIO  
DEPARTMENT OF HEALTH

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6253**

**364**  
BIRTH NO. **6253**

1. NAME OF DECEASED (Type or Print) <b>KATHARINE STERLING</b>		2. DATE OF DEATH <b>July 17, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>6 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>930 Quantril Way</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Dec. 24, 1913</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	9. AGE (In years last birthday) <b>36</b>
13. FATHER'S NAME <b>Guy Paull</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co., Pa.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. SOCIAL SECURITY NO. <b>-</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Welker</b>	
17. INFORMANT <i>Sheld. Sterling 930 Quantil Rd.</i>		ADDRESS	

18. <b>443 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Idiopathic epilepsy</b> <b>Reactive depression</b>		
(B) DUE TO		
(C)		
19A. DATE OF OPERATION <b>6</b>		19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **Inquiry & Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley H. Decker</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR		23C. DATE SIGNED <b>July 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-20-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Waynesboro, Pa.</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		25. FUNERAL DIRECTOR <b>Walter Y. Grove - Waynesboro, Pa.</b>	
REGISTRAR'S SIGNATURE <i>Huntington Williams, Jr.</i>		ADDRESS <i>Walter Y. Grove 930 Quantil Rd.</i>	

CERTIFICATE OF DEATH

WITNESSED BY TWO OR MORE OF THE FOLLOWING:

10-1

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

NAME OF DECEASED

RESIDENCE OF DECEASED

SIGNATURE OF DECEASED

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER

DATE OF SIGNATURE

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NAME OF SIGNER

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NAME OF SIGNER

DATE OF SIGNATURE

PLACE OF SIGNATURE

NAME OF SIGNER



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6254  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Amanda Paulus</b>		2. DATE OF DEATH <b>7.14.50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Doctors Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Doctors Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Glen Burnie 5200</b>	
C. Length of stay in Baltimore <b>10 years</b>		D. STREET ADDRESS (If rural, give location) <b>423 Cross Highway, Glen Burnie</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>3.31.1890</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>60</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>A.A. County Md.</b>	
13. FATHER'S NAME <b>Elijah W. Wood</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Anna Gertrude Shelby</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Catherine Heath Glen Burnie Md.</b>	

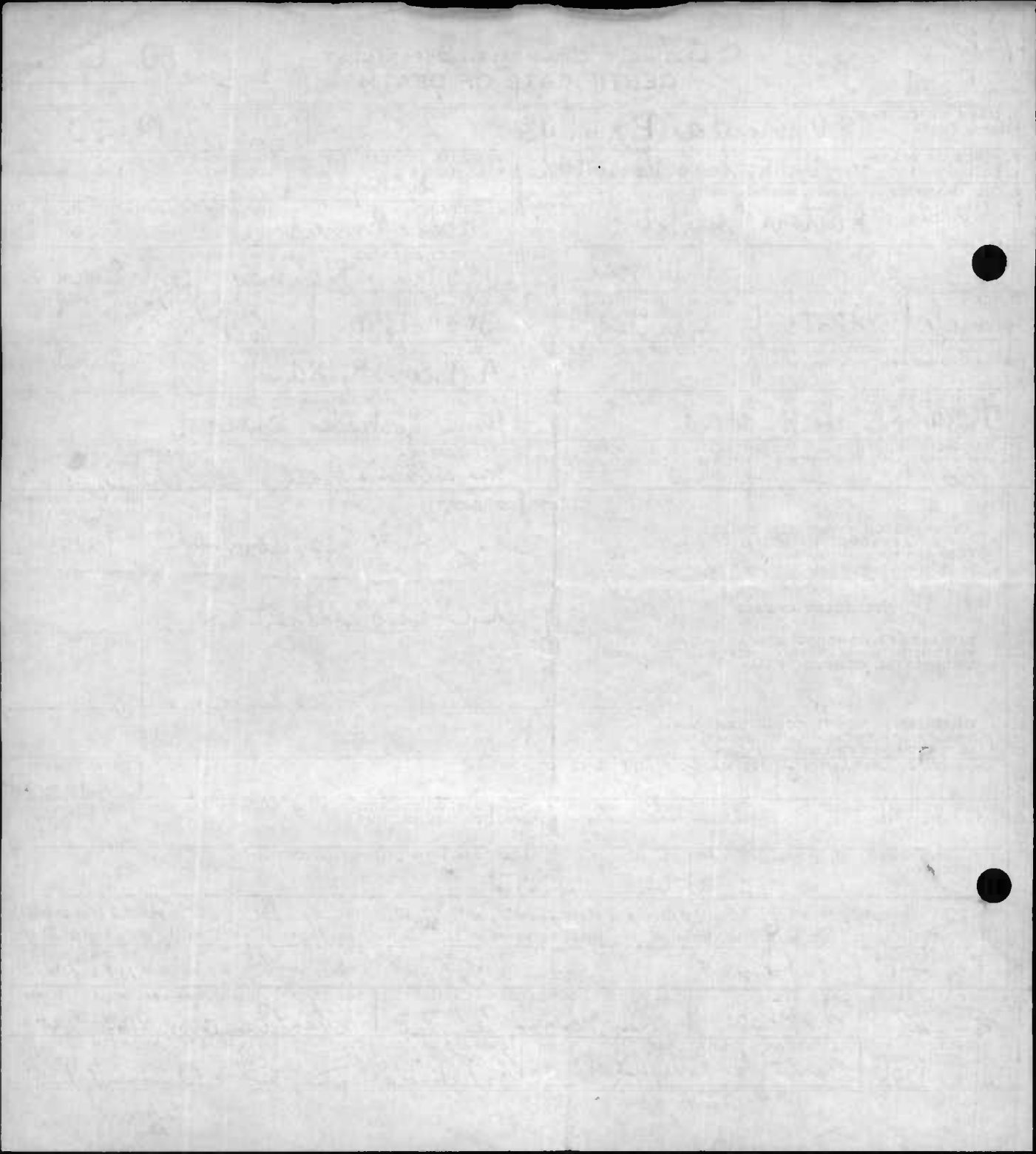
18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
(A) DUE TO <b>Anterocedalus</b>		
(B) DUE TO		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		
(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **7-7-50** 19**50**, to **7-14**, 19**50**, that I last saw the deceased alive on **7-14**, 19**50**, and that death occurred at **11:30** p.m., from the causes and on the date stated above.

23A. SIGNATURE <b>Donald J. Fox</b>		23B. ADDRESS <b>2730 N. Charles St.</b>		23C. DATE SIGNED <b>7/15/50</b>	
--	--	--	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-18-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, A.A. Co. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. H. Williams, M.D.</b>		ADDRESS <b>Glen Burnie, Md.</b>	



320

6255

JL-139757

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50

6255

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

William Johnson Ritchey

2. DATE  
OF  
DEATH

7-16-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street address or location)  
Baltimore City Hospitals  
4940 Eastern Ave.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

Md.

Baltimore

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

Middle River

D. STREET ADDRESS (If rural, give location)

46 Kingston Rd. Middle River

c. Length of stay in Baltimore

26 yrs.

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

May 26, 1885

9. AGE (In years  
last birthday)

65

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Carmaker, B &amp; O R. R.

10B. KIND OF BUSINESS OR  
INDUSTRY

B &amp; O R. R. Co.,

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Albert Ritchey

14. MOTHER'S MAIDEN NAME

Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
705-09-1530

17. INFORMANT

ADDRESS

B. C. H. Records, 4940 Eastern Ave.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ No ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from July 15, 1950, to July 16, 1950 that I last saw the  
deceased alive on July 16, 1950, and that death occurred at 7.05 PM from the causes and on the date stated above.

23A. SIGNATURE

J. H. Rogers M. D.

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

7-16-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Removal

24B. DATE

7/20/50

24C. NAME OF CEMETERY OR CREMATORY

Altoona, Pa.

24D. LOCATION (City, town, or county)

Altoona, Pa.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

JUL 17 1950

25. FUNERAL DIRECTOR

Schimunek Funeral Home, Inc. 2801-05-05 E. Madison St.,

ADDRESS

VS 150

69050

94a

MEDICAL CERTIFICATION

1200-1-2

William Johnson

Assistant Secretary

U.S. Department of the Interior

Washington, D.C.

March 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

Wm. Johnson

Assistant Secretary

U.S. Department of the Interior

Washington, D.C.

March 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,

Wm. Johnson

Assistant Secretary

U.S. Department of the Interior

Washington, D.C.

# (Medical) Examiners Case

Released to Hospital BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 6256

BIRTH NO. 6256

1. NAME OF DECEASED (Type or Print) <b>LILLIE DOROTHEA STALFORT</b>		2. DATE OF DEATH <b>July 16, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>8-06</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1637 N. Broadway</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>3-25-85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	9. AGE (In years last birthday) <b>65</b>
13. FATHER'S NAME <b>Gerhardt E.C. Stafort</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>None</b>		14. MOTHER'S MAIDEN NAME <b>Helena Denkhe</b>	
		17. INFORMANT <b>JOHNS HOPKINS HOSPITAL</b>	

18. <b>E 900.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(A) <b>Acute cor pulmonale</b>	<b>24 hrs</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO <b>Right hemothorax, Compression atelectasis, left hydrothorax</b>	<b>72 hrs.</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT		(B) <b>Laceration of rt. lung from internal</b>	<b>72 hrs</b>
		(C) <b>compound fracture of rt. 8th rib</b>	<b>18 + mos.</b>

19A. DATE OF OPERATION <b>7/13</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <b>A</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1637 N. Broadway</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 13 1950 PM.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Flipped + Fall down steps</b>	
22. I hereby certify that I attended the deceased from <b>7-13</b> 1950, to <b>7-16</b> 1950, that I last saw the deceased alive on <b>7-16</b> 1950, and that death occurred at <b>12:30 PM.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Marjorie Jean Fortz M.D.</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>July 16, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/18/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. FUNERAL DIRECTOR <b>HENRY SANDER &amp; SONS, INC.</b>		24F. ADDRESS <b>NORTH AVE. &amp; BROADWAY -13</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		VS 150 <b>N-861.00</b>	

Certificates to be approved by Medical Examiner

Billie Stalport

Female White Single

18 yrs  
15 yrs  
12 yrs  
10 yrs  
8 yrs  
6 yrs  
4 yrs  
2 yrs  
1 yr

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560  
50 6257HANAWER  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6257  
Registered No.

BIRTH NO.

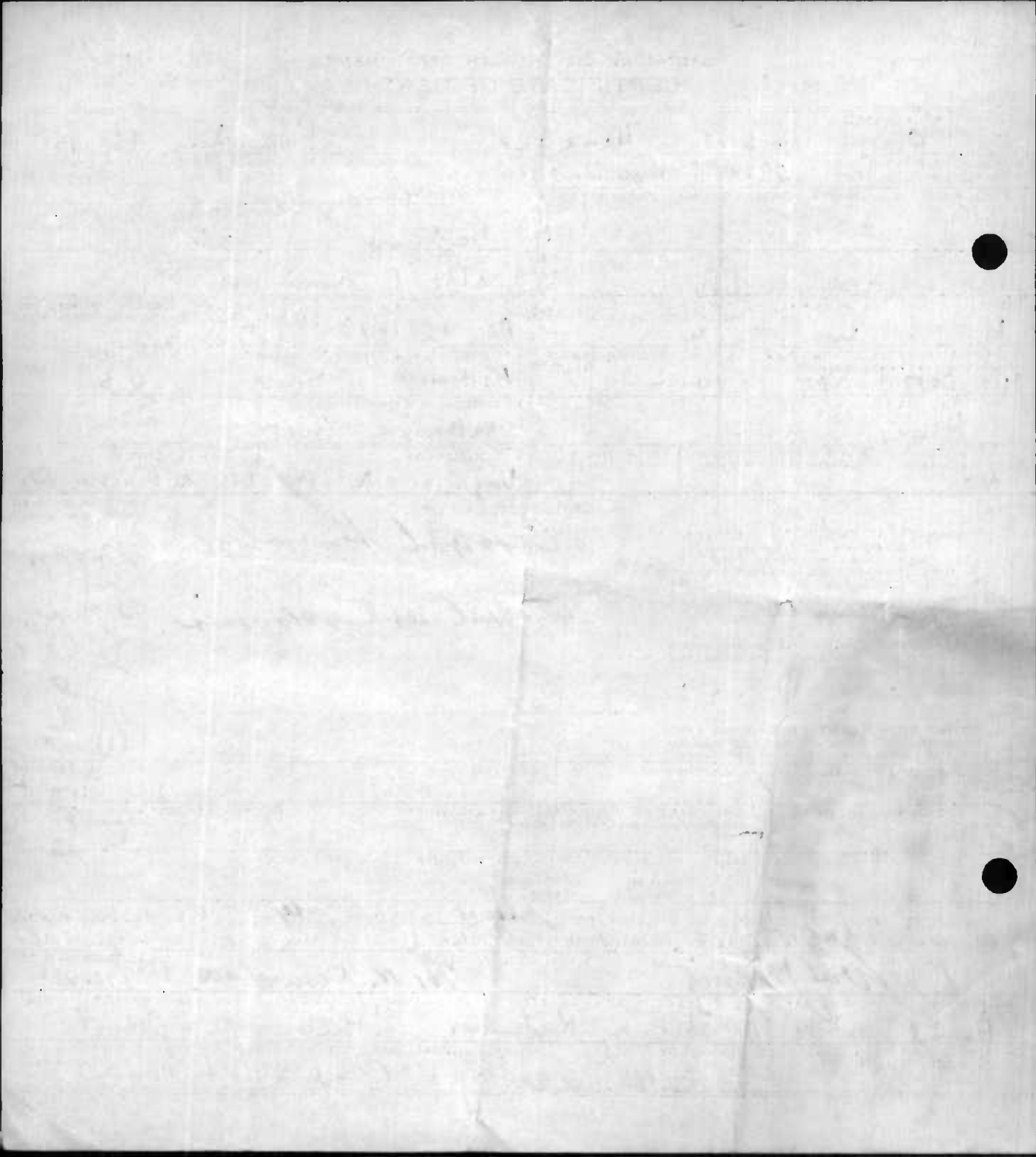
1. NAME OF DECEASED (Type or Print) <b>George Norbert Hanawer</b>			2. DATE OF DEATH <b>July 15, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2929 E. Monument St.</b>			4. USUAL RESIDENCE (Where deceased lived, institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Life</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 7-01</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>2929 E. Monument St.</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>w</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M</b>	8. DATE OF BIRTH <b>Dec. 25, 1873</b>	9. AGE (In years; last birthday) <b>76</b>	10. Under 1 Year Months: <b>6</b> Days: <b>6</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Five Dept. Capt.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Fireman</b>		
13. FATHER'S NAME <b>Henry</b>			14. MOTHER'S MAIDEN NAME <b>Katherine Burk.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Virginia Nitsch</b>			ADDRESS <b>615 N. Denison St.</b>		

18. <b>331X I</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <b>Cerebral hemorrhage.</b>	<b>2 1/2 days</b>
ANTECEDENT CAUSES	(B) <b>Cerebral arteriosclerosis.</b>	<b>3 years.</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C) ...	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 13</b> , 19 <b>50</b> , to <b>July 15</b> , 19 <b>50</b> that I last saw the deceased alive on <b>July 15</b> , 19 <b>50</b> , and that death occurred at <b>11:30 A.</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>W. J. Smith</b>		23B. ADDRESS <b>201 N. Kenwood Ave.</b>		23C. DATE SIGNED <b>July 16, 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 19, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Maryland.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 17 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Huntington Williams</b>	
24G. FUNERAL DIRECTOR <b>Phyl E. Cochrane</b>		24H. ADDRESS <b>2716 E. Monument St.</b>		24I. VS 150	

6250

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6258

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

EDWARD (VANDERBERGER) VANDIVEER

2. DATE  
OF  
DEATH

July 14, 1950

## 3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

6-05

D. STREET ADDRESS (If rural, give location)

122 Jackson Place

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

## 5. SEX

male

## 6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDDED, DIVORCED (Specify)

Single

## 8. DATE OF BIRTH

Jan. 28-1890

9. AGE (in years  
last birthday)

60

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Sheet Metal Worker Fairfield Shipyard

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

## 13. FATHER'S NAME

John Vandiver

## 14. MOTHER'S MAIDEN NAME

Catherine Cunningham

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

## 17. INFORMANT

ADDRESS

Catherine C. Guernsey 5739 Belmont Ave

18. 002X

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHI  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

## 19A. DATE OF OPERATION

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

## 23A. SIGNATURE

B. F. Fisher

M.D.

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☐  
MEDICAL INVESTIGATOR.....☐

## 23C. DATE SIGNED

July 15, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

## 24B. DATE

July 18/50

## 24C. NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

## 24D. LOCATION (City, town, or county)

Balto.

(State)

Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

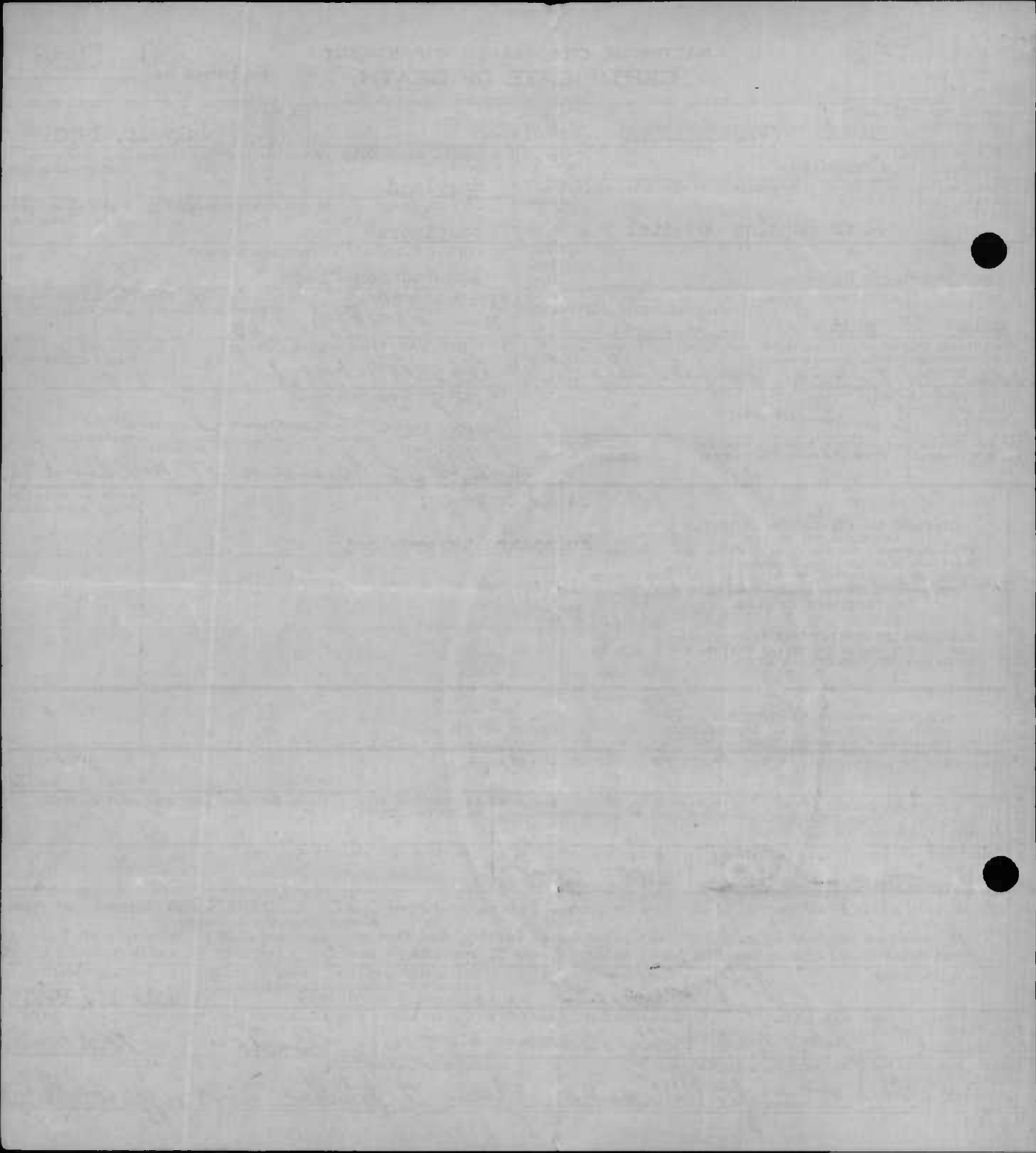
## REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

## 25. FUNERAL DIRECTOR

ADDRESS

John A. Miller 2334 Jefferson St.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6259

BIRTH NO. 365

1. NAME OF DECEASED (Type or Print) <u>Mrs. Katherine W. Tewksbury</u>		2. DATE OF DEATH <u>7-17-50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>6420 Reisterstown Road</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>New York</u> B. COUNTY <u>V-29</u>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>The Seton Institute</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <u>Buffalo</u>	
c. Length of stay in Baltimore <u>7</u> Yrs. <u>4</u> Mos. <u>9</u> Days		D. STREET ADDRESS (If rural, give location)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>divorced</u>	8. DATE OF BIRTH <u>? - - 1876</u>
9. AGE (In years last birthday) <u>74</u>		10. UNDER 1 YEAR Months: Days	10. UNDER 24 HOURS Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Greenlow</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>The Seton Institute - 6420 Reisterstown Rd. Balto.</u>		ADDRESS	

18. <u>446 X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Anemia</u> DUE TO (B) <u>chronic nephritis</u> DUE TO <u>Arteriosclerosis</u> <u>Involuntional Melancholia over 7 yrs.</u>	INTERVAL BETWEEN ONSET AND DEATH <u>1 mo. dur.</u>  <u>over</u>
--	--	--

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 9, 1941</u> , to <u>July 17, 1950</u> , that I last saw the deceased alive on <u>July 17, 1950</u> , and that death occurred at <u>12:45 a. m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>James T. Lewis, M.D.</u>		23B. ADDRESS <u>6420 Reisterstown Rd</u>		23C. DATE SIGNED <u>7/17/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial July 18-50</u>		24B. DATE <u>July 18-50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>		24E. FUNERAL DIRECTOR <u>Shubert Mortuary</u>		ADDRESS <u>Balto.</u>	

Letter in document file 50-6259- 7/31/50.



150  
50 6260BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6260

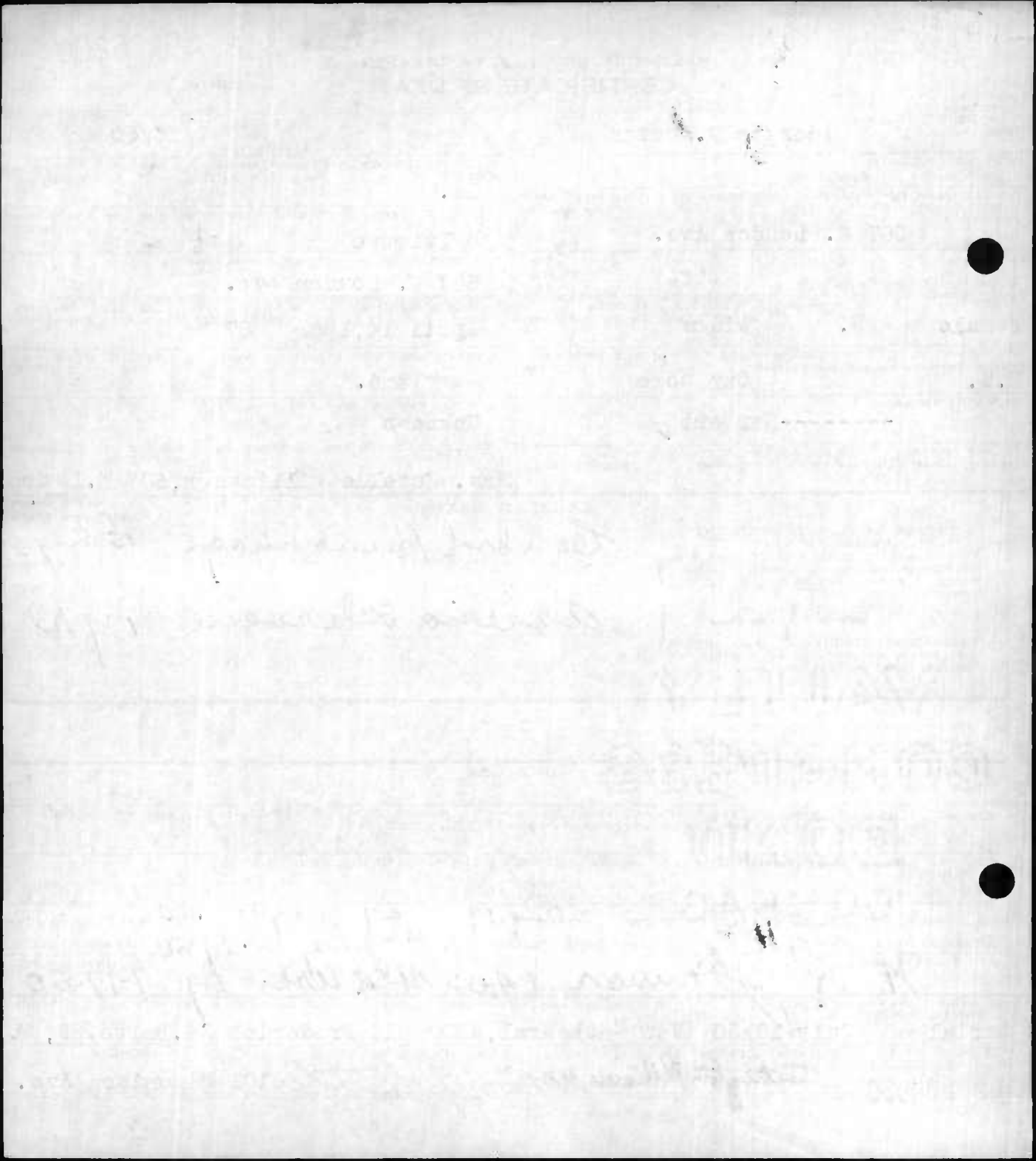
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Georgie F. Bevan</b>		2. DATE OF DEATH <b>7/15/50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>607 N. Loudon Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 16-08</b>			
C. LENGTH OF STAY IN BALTIMORE <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>607 N. Loudon Ave.</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>April 14, 1863</b>	9. AGE (in years last birthday) <b>87</b>	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>-----Herbert</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Estelle Williamson, 607 N. Loudon Ave.</b>			

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterio sclerosis</b> DUE TO <b>1 yk</b>	INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Aug. 19</b> to <b>July 11, 1950</b> , that I last saw the deceased alive on <b>July 11, 1950</b> , and that death occurred at <b>11:30 a.m. July 15, 1950</b> .					
23A. SIGNATURE <b>H. R. Johnson</b>		23B. ADDRESS <b>403 Med Arts Bg</b>		23C. DATE SIGNED <b>7-17-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 18/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral, 4300 Old Frederick Rd. Balto. 29, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. 29, Md.</b>		25. FUNERAL DIRECTOR <b>Harry A. Witzke</b>		ADDRESS <b>4101 Edmondson Ave.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md.</b>		VS 150	

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514  
50 6261BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6261

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGIA WALLACE Knobel</b>		2. DATE OF DEATH <b>July 17, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2403 CHELSEA TERRACE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 15-38</b>			
C. Length of stay in Baltimore <b>35 YRS.</b>		D. STREET ADDRESS (If rural, give location) <b>2403 CHELSEA TERRACE</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	B. DATE OF BIRTH <b>DEC. 10, 1877</b>	9. AGE (In years last birthday) <b>72</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>	
13. FATHER'S NAME <b>JACKSON L. WALLACE</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN T. Gibbs</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>CAROL Robinson 2403 CHELSEA TER.</b>	
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> DUE TO <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CON- TRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH <b>Cerebral hemorrhage</b> DUE TO <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1/2 hour</b>			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>9/19, 1948</b> , to <b>7/17, 1950</b> that I last saw the deceased alive on <b>6/26, 1950</b> , and that death occurred at <b>2:30 Pm.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Robert A. Reiter</b>		23B. ADDRESS M. D. <b>340 E Windsor Ave</b>		23C. DATE SIGNED <b>7/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>July 19, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. County Md.</b>		25. FUNERAL DIRECTOR <b>George L. Schwab</b>		ADDRESS <b>210, Frederick Ave.</b>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

630.  
50 6262

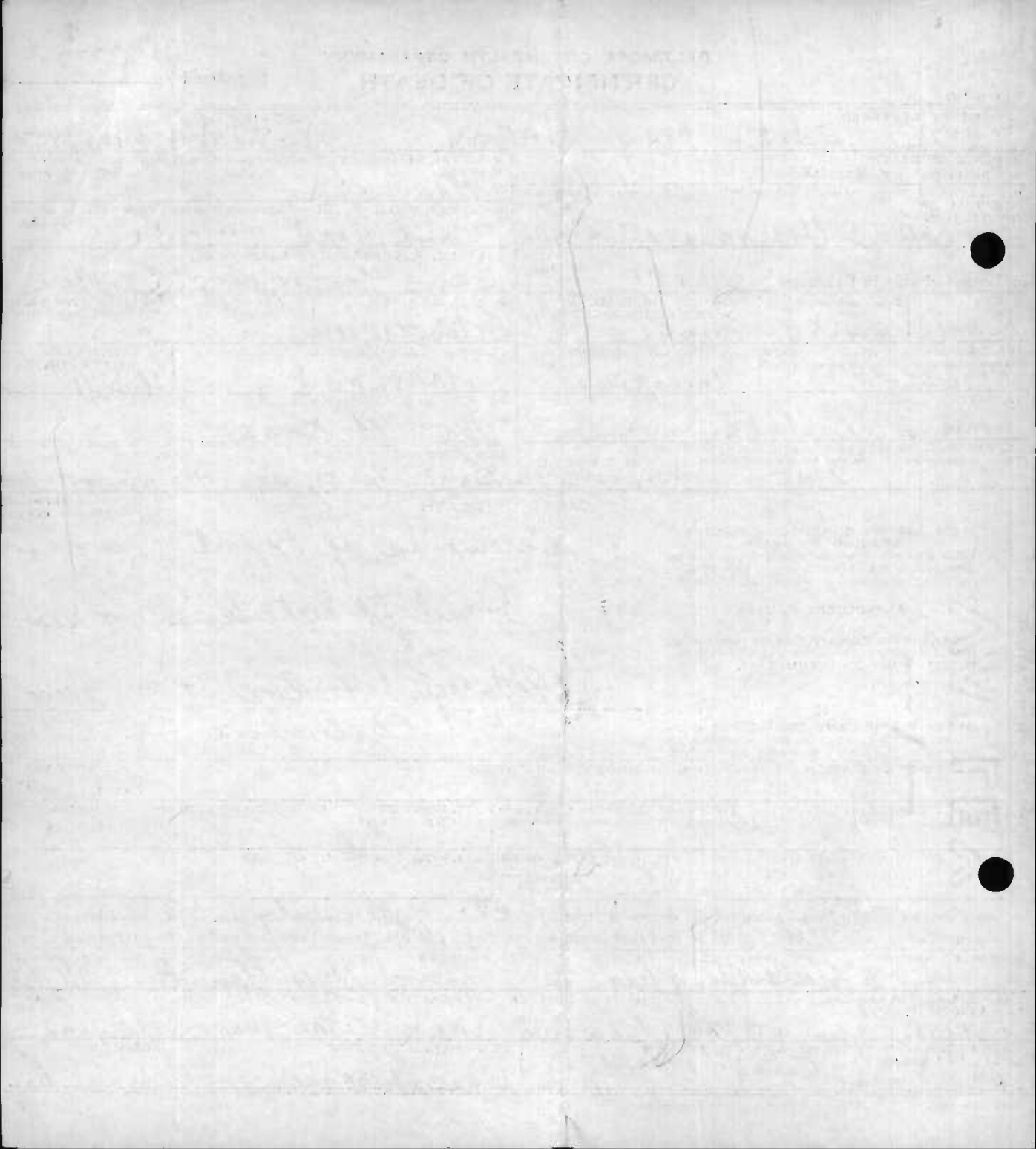
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6262  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Edith May Hardy</b>		2. DATE OF DEATH <b>July 16, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>3223 Massachusetts Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 20-06</b>			
C. Length of stay in Baltimore <b>LIFE</b>		D. STREET ADDRESS (If rural, give location) <b>3223 Massachusetts Ave</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>October 15, 1896</b>	9. AGE (In years last birthday) <b>53</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presser</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Tailoring</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES R. Hardy, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>DORA M. Koss.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-3550</b>		17. INFORMANT <b>FRANK HARDY</b>	
18. <b>170X</b>		CAUSE OF DEATH		ADDRESS <b>3223 Massachusetts Ave</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Carcinoma of Breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
DUE TO		(B) <b>Generalized Metastasis</b>		<b>8 mos.</b>	
ANTECEDENT CAUSES		(C) <b>Pathological Fracture Lt. Hip. Cachexia.</b>		<b>6 mos.</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Oct.</b> , 19 <b>47</b> , to <b>July</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/14</b> , 19 <b>50</b> , and that death occurred at <b>1230 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>R. Kulevitz, M.D.</b>		23B. ADDRESS <b>244 N. Hilton St.</b>		23C. DATE SIGNED <b>7/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>July 19, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Louisa PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		25. FUNERAL DIRECTOR <b>George L. Schwab</b>		ADDRESS <b>3101 Frederick Ave</b>	

MEDICAL CERTIFICATION

64386 201





50 6263

REA-139807

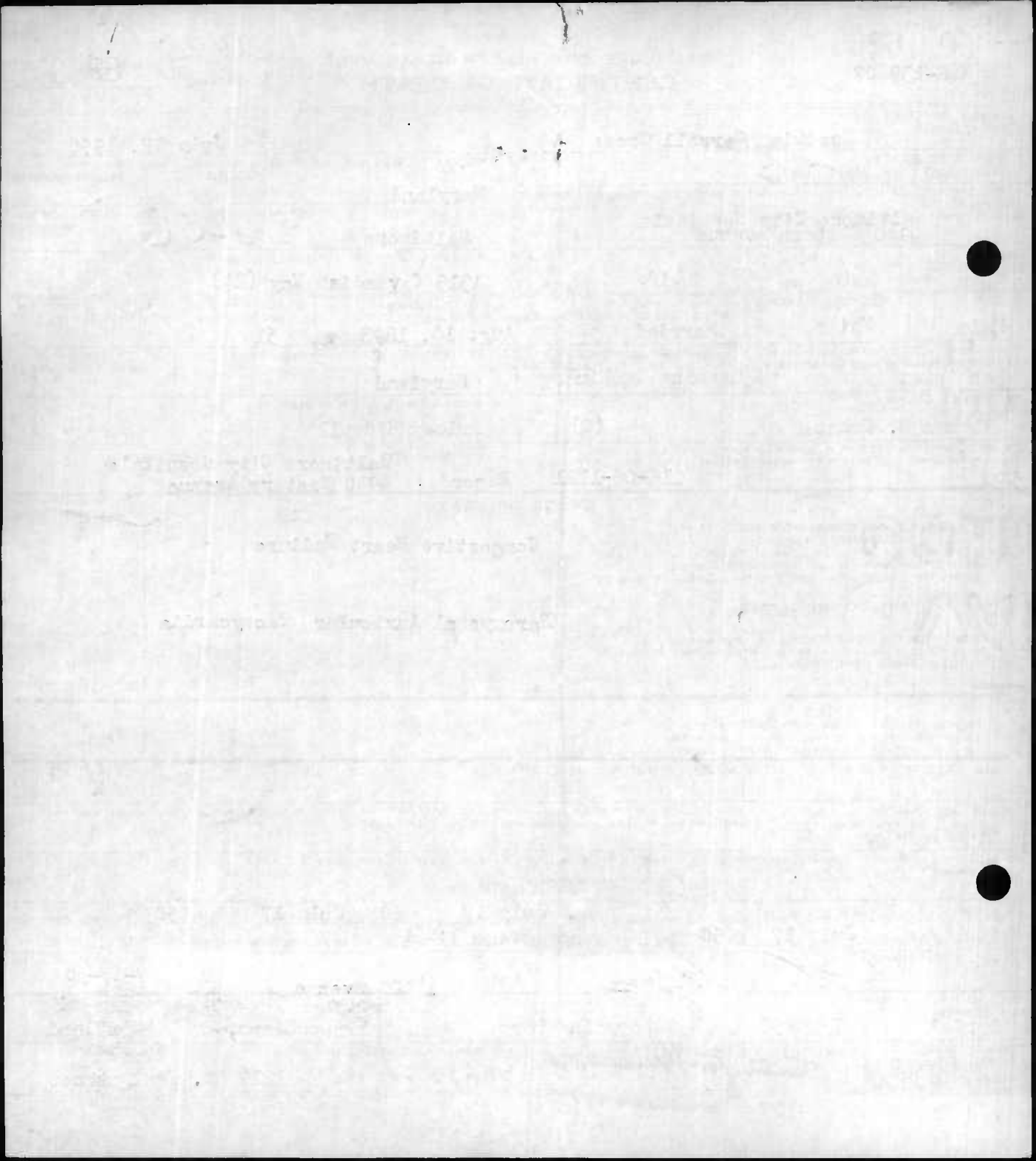
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

JUL 18 1950

Registered No. 50 6263

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Hezikiah Carroll Cross</b>		2. DATE OF DEATH <b>July 17, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>X</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>26-06</b>	
c. Length of stay in Baltimore <b>Life</b> Yrs. <b>Life</b> Mos. <b>Life</b> Days <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>1313 Cavendish Way (24)</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 10, 1898</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Canning Machinery</b>	9. AGE (in years last birthday) <b>51</b>
13. FATHER'S NAME <b>Thomas G. Cross (D)</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>(D)</b>	
16. SOCIAL SECURITY NO. <b>215-05-1121</b>		14. MOTHER'S MAIDEN NAME <b>Pricey Kidwell (D)</b>	
18. <b>433.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Congestive Heart Failure</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Paroxysmal Auricular Tachycardia</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		17. INFORMANT <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Avenue</b>	
19A. DATE OF OPERATION <b>7/20/50</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 17, 1950</b> , to <b>July 17, 1950</b> , that I last saw the deceased alive on <b>July 17, 1950</b> and that death occurred at <b>3:45 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS <b>4940 Eastern Avenue</b>	
23C. DATE SIGNED <b>7-17-50</b>		24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	
24B. DATE <b>7/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>		DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>	
REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>	
ADDRESS <b>1217 St. Paul Street</b>			



626  
50 6264BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6264

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EVA BRIEGER</b>		2. DATE OF DEATH <b>7/18/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓ B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>104 W. Clay Street</b>			
c. Length of stay in Baltimore <b>3 yrs.</b>		8. DATE OF BIRTH <b>June 23, 1882</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>White</b>		9. AGE (In years last birthday) <b>68 yrs</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife.</b>		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>Spin on Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Emma Weiss</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Charles M. E. Brieger, 104 W. Clay St</b>	
18. <b>175X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>adenocarcinoma of ovary.</b> CAUSE OF DEATH (A) <b>adenocarcinoma of ovary.</b> DUE TO (B) <b>ovary.</b> DUE TO (C) <b>ovary.</b> INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION <b>7-9-50</b>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-9-50</b> to <b>7-17-50</b> , that I last saw the deceased alive on <b>7-16-50</b> , and that death occurred at <b>12:30 A.M.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Donald J. [Signature]</b>		23B. ADDRESS <b>Church Home &amp; Hospital</b>		23C. DATE SIGNED <b>7/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>7/18/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul Street</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>			



500  
50 6265BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6265

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

TIEHIE COHEN

2. DATE  
OF  
DEATH

7-17-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland 2476 Shirley Ave

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION Mt Carmel Home4. USUAL RESIDENCE: (Where deceased lived, If institution: residence  
before admission)

A. STATE Md

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3712 Ewyn Oak Ave

c. Length of stay in Baltimore

40 Yrs.  
Mons.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

7/1

9. AGE (In years

last birthday)

71

If Under 1 Year

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

Shaiah

11. BIRTHPLACE (State or foreign country)

Russia

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Tolce

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Max Cohen 1614 Ruxton Ave

ADDRESS

18. 260X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

diabetes mellitus

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

vascular degeneration-amputation

INTERVAL BETWEEN  
ONSET AND DEATHabout  
25 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 5, 1950, to July 17, 1950 that I last saw the  
deceased alive on July 16, 1950, and that death occurred at 2 P. M., from the causes and on the date stated above.

23A. SIGNATURE

Dr. Herman Seidel

M. D.

23B. ADDRESS

2404 Eutaw Pl.

23C. DATE SIGNED

7/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7-18-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Mt Carmel

24D. LOCATION (City, town, or county)

Baltimore Md

DATE RECEIVED BY  
LOCAL BOARD

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Eutaw Pl

Seidel  
2404 Buttons PE

VALLEY  
CONGRESS



410  
50 6266BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6266  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MORRIS WOLF</b>		2. DATE OF DEATH <b>7-17-50</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <b>Md</b> b. COUNTY			
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>3900 Reestertown Road</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 15-12</b>			
c. Length of stay in Baltimore <b>Life</b>		d. STREET ADDRESS (If rural, give location) <b>3900 Reestertown Road</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>36</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Supt. Post office</b>		11. BIRTH PLACE (State or foreign country) <b>Baltimore Md</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Jacob</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Rose Wolf</b> ADDRESS <b>- Lane</b>	
18. <b>434.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Pneumoniae edema</b> DUE TO <b>Cerebral Hypertrophy + Failure</b> (B) <b>Anemia -</b> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>Jan 1950</b>		19. DATE OF OPERATION <b>0</b> 19b. MAJOR FINDINGS OF OPERATION <b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan 27, 1948</b> to <b>July 17, 1950</b> that I last saw the deceased alive on <b>July 17, 1950</b> and that death occurred at <b>12:50 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE <b>Rebecca Korman</b>		23b. ADDRESS <b>3700 Dash Heights</b>		23c. DATE SIGNED <b>July 17, 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>7-18-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Herring Cem</b>	
24d. LOCATION (City, town, or County) (State) <b>Balto Md</b>		24e. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>		24f. ADDRESS <b>2100 Eutaw Pl</b>	

MEDICAL CERTIFICATION

Kolman

200  
50 6267

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6267

1. NAME OF DECEASED (Type or Print) <b>OSCAR MAAS</b>			2. DATE OF DEATH <b>7/16/50</b>		
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>BALTO MA</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MD</b> b. COUNTY		
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST PAUL NURSING HOME 2305 ST PAUL ST</b>			c. CITY OR TOWN (If outside corporate limits, write FULL and give township) <b>BALTO 19-04</b>		
c. Length of stay in Baltimore <b>40 YRS</b>			d. STREET ADDRESS (If rural, give location) <b>1623 RAMSEY ST</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>NOV 7 1876</b>		9. AGE (In years, last birth day) <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHECKER</b>		10b. KIND OF BUSINESS OR OCCUPATION <b>RUGGERS YORKTOWN AVE.</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>			12. CITIZEN OF WHAT COUNTRY? <b>NOT KNOWN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-12-4222</b>		17. INFORMANT <b>JOS KORTUM.</b>	
				ADDRESS <b>401 S. MOUNT ST</b>	

MEDICAL CERTIFICATION

18. <b>332X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Cerebral Thrombosis</b> DUE TO (B) <b>age</b> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <b>one month</b>								
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <b>6-16-</b> , 19 <b>50</b> , to <b>July 16</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-13-</b> , 19 <b>50</b> , and that death occurred at <b>1:22</b> p.m., from the causes and on the date stated above.								
23a. SIGNATURE <b>[Signature]</b>		23b. ADDRESS <b>3415 Fulton Ave</b>		23c. DATE SIGNED <b>7-17-50</b>				
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>OS.</b>		24b. DATE <b>7/19/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>GOODSHEPARK</b>		24d. LOCATION (City, town, or county) (State) <b>ROCKDALE MD.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR <b>GEO H. LEINBACH</b>		ADDRESS <b>22 N. LYNDALE ST</b>		

390 63 6266 830

2000 MAR 20

AM 07:00

1. 2000 MAR 20

2000

2. 2000 MAR 20

3. 2000 MAR 20

4. 2000 MAR 20

5. 2000 MAR 20

520

50 6268

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6268

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>C. FLETCHER THOMAS</i>		2. DATE OF DEATH <i>July 17 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write R.R. and give township) <i>Baltimore</i> <i>8-04</i>			
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>2223 E. Oliver St.</i>			
5. SEX <i>Male</i>	6. COLOR OF RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb 13, 1888</i>	9. AGE (In years last birthday) <i>62</i>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Night Watchman Retired - Western Md. R.R.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Wesley Thomas</i>		14. MOTHER'S MARDEN NAME <i>Mary Roberts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>705-10-81167</i>		17. INFORMANT <i>(SON) Howard Thomas</i>	
18. <i>193X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Brain tumor or Encephalitis</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <i>Tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5-6 weeks</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>None</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <i>Not related</i>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <i>Not pertinent</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 29, 1950</i> , to <i>July 17, 1950</i> , that I last saw the deceased alive on <i>July 17, 1950</i> , and that death occurred at <i>2:00 AM</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Frank P. Kasik, Jr.</i>		23B. ADDRESS <i>3630 Elkhader Rd</i>		23C. DATE SIGNED <i>July 17 1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>7-20-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>London Pk Cem</i>	
24D. LOCATION (City, town, or county) (State) <i>Fredrick Rd. Balto Md.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 18 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>	
24G. FUNERAL DIRECTOR <i>John P. Miller</i>		24H. ADDRESS <i>2435 E. Oliver St</i>		24I. VS 150	

763 50

54B

Autopsy findings - Dr. Kank, 90, Mary King.

C.D. report card to The Queen, 7/21/50

"Tuberculoma of brain"

Disseminated Tuberculosis, spleen, kidney, etc.

Also see Document File 50-6268<sup>ES</sup>

Brain Tumor - "malignant"

8-24-50

ES



400  
50 6269

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6269  
Registered No.

BIRTH NO.  
1. NAME OF DECEASED (Type or Print) *Joseph A. Pauly* 2. DATE OF DEATH *July 17, 1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Maryland* B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
*545 Wellesley St.* C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
*Baltimore 20-06*

D. STREET ADDRESS (If rural, give location)  
*545 Wellesley St*

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX *Male* 6. COLOR OR RACE *White* 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Married* 8. DATE OF BIRTH *July 4, 1882* 9. AGE (In years, last birthday) *68* 10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Silver smith* 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) *Germany* 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Julius C. Pauly* 14. MOTHER'S MAIDEN NAME *Bertha Spynell*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. *579-01-0494* 17. INFORMANT *John E. Pauly* ADDRESS *713 Edgewood St*

18. *420.1* CAUSE OF DEATH *Coronary Disease* INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO

ANTECEDENT CAUSES (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

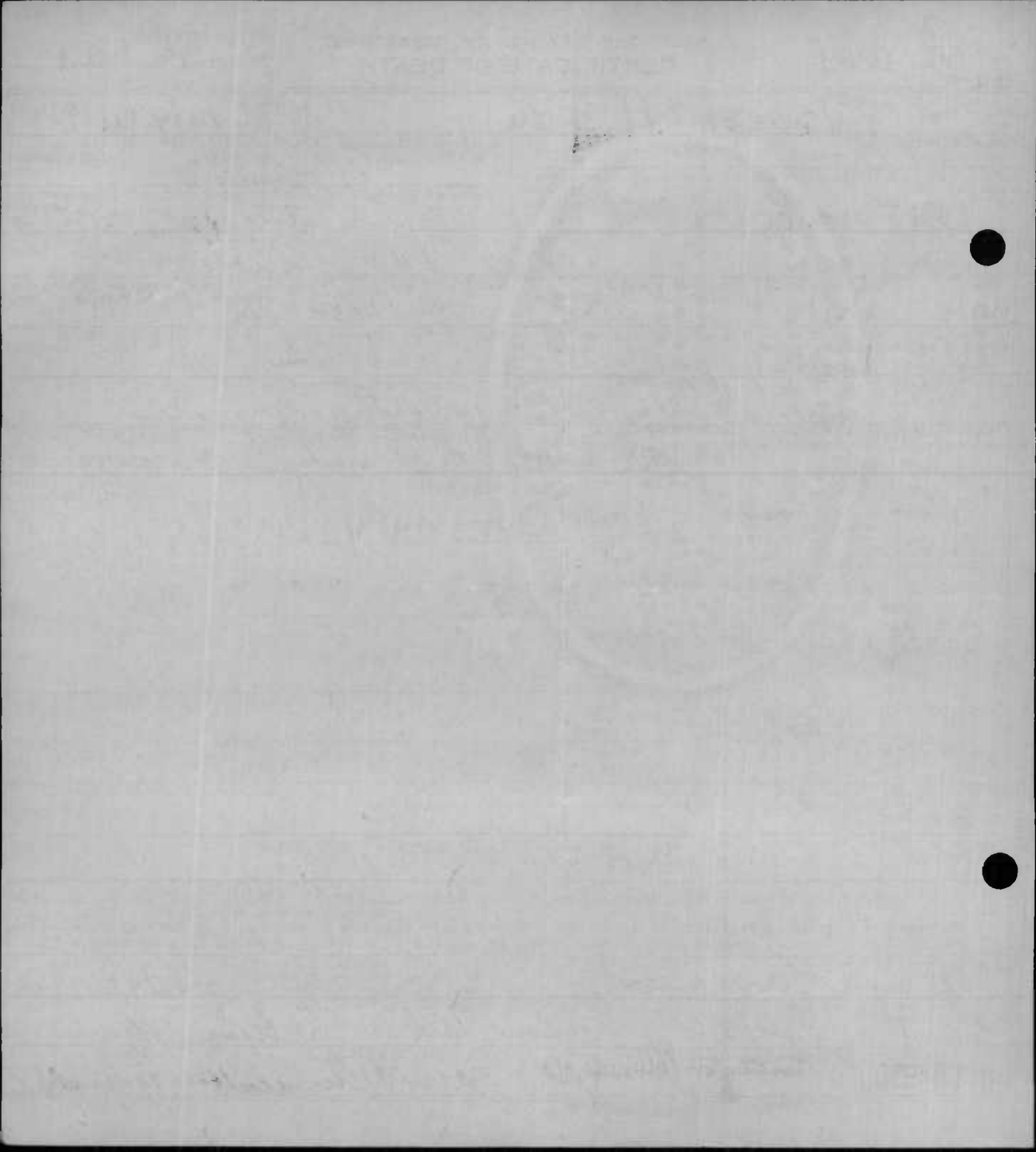
22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE *Wm. H. Kammer, Jr.* 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED *July 17, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 24B. DATE *July 20, 1950* 24C. NAME OF CEMETERY OR CREMATORY *London Park* 24D. LOCATION (City, town, or county) (State) *Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR *JUL 18 1950* REGISTRAR'S SIGNATURE *Frederick William, M.D.* 25. FUNERAL DIRECTOR *Harry H. Amaco* ADDRESS *4204 Redbank*

VS 151 53432 94a



462  
50 6270BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6270

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Frank Clark

2. DATE  
OF  
DEATH

July 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2101 Coldspring Lane

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1009 Harlem Ave.

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

April 10, 1878

9. AGE (In years,  
last birthday)

72

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Club

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Frank Clark

14. MOTHER'S MAIDEN NAME

Laura Frederick

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Ida. Spencer 1009 Harlem Av.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ...

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) ...

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) ...

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/17, 1950, to 7/17, 1950, that I last saw the  
deceased alive on 7/15, 1950, and that death occurred at 8:45 a. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

7-20-50

Arbutus Mem. Park

Baltimore Co., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 18 1950

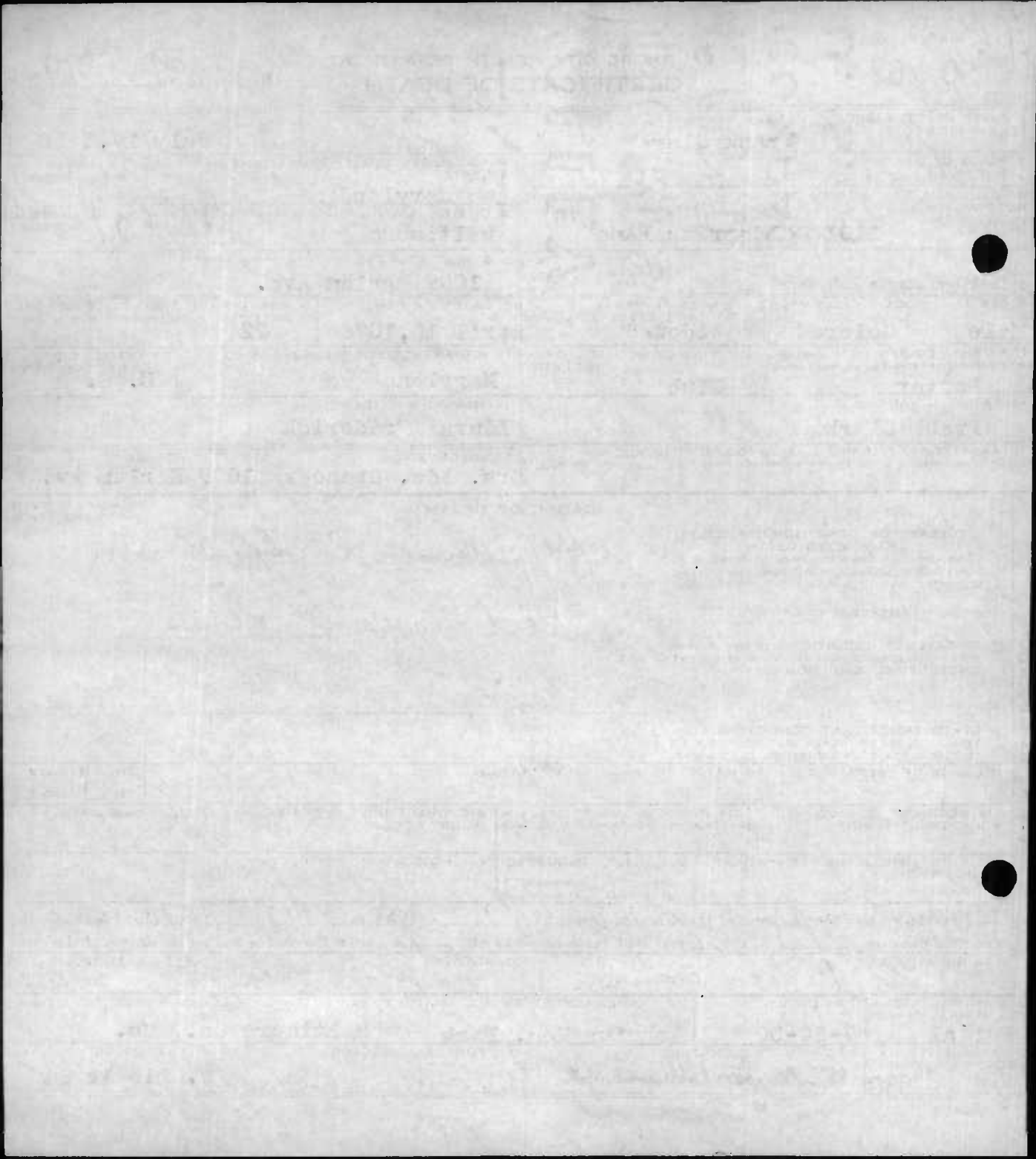
Huntington Williams, M.D.

Matthias G. Hemmley W. Biddle St

VS 150

780-8X-260

131a



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6271

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

JAMES J. FOGARTY

2. DATE  
OF  
DEATH

July 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

St. Joseph's Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1013 Bonaparte Avenue

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Aug. 1, 1901

9. AGE (In years  
last birthday)

48

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Police

10B. KIND OF BUSINESS OR  
INDUSTRY  
Baltimore City

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James J. Fogarty

14. MOTHER'S MAIDEN NAME

Anna A. McKewen

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mary O. Fogarty 1013 Bonaparte Avenue

18. 422-1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY21E. INJURY OCCURRED  
WHILE AT ☐ NOT WHILE  
WORK ☐ AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED

July 17, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

V S 151

773 932 70

93D

WASHINGTON CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1921

1921

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE



30

50 6272

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6272  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDWIN DAY HEALD</b>		2. DATE OF DEATH <b>7/17/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MO.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. JOSEPH'S HOSP.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BARTO.</b> <b>11-02</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>4 E BIDDLE ST.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Nov. 19, 1876</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Drugs (W)</b>	9. AGE (In years last birthday) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Sonia Heald - 4 E. Biddle St.</b>		ADDRESS	

18. **180X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) **Carcinoma of left kidney**  
DUE TO **with peritoneal metastases**

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>6/21/50</b> , 19 <b>50</b> , to <b>7/17/50</b> , that I last saw the deceased alive on <b>7/16/50</b> , and that death occurred at <b>12:04</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Maddaus Swinski</b> M. D.		23B. ADDRESS <b>St. Joseph's Hosp.</b>		23C. DATE SIGNED <b>7/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/18/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>26 m. J. Lickens &amp; Sons, Balto.</b>	
				ADDRESS <b>52a Md.</b>	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

38

200

100

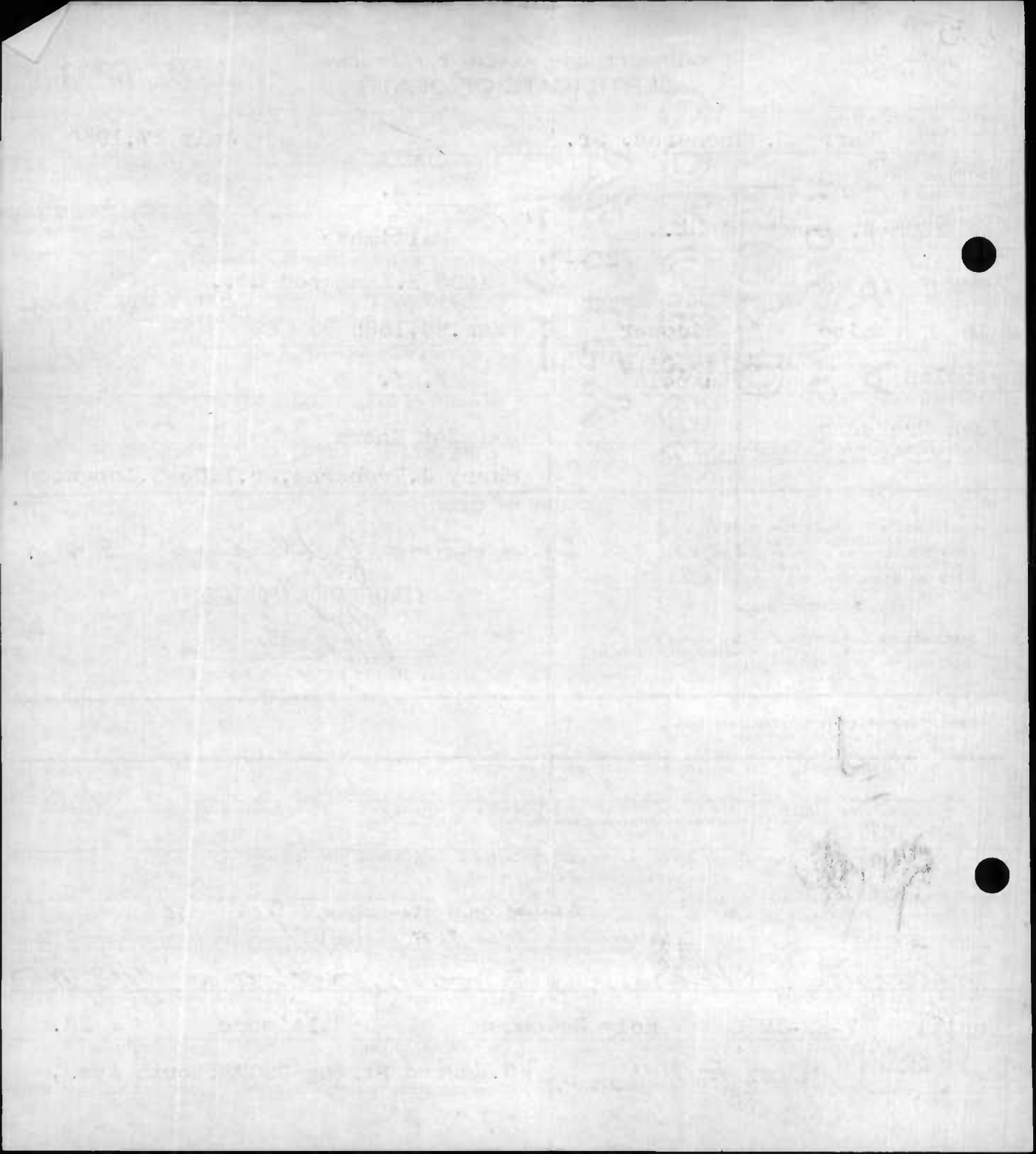
**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6273

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>Harry J. Treherne, Sr.</b>		2. DATE OF DEATH <b>July 17, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1605 N. Longwood St.,</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>1605 N. Longwood St.,</b>		E. LENGTH OF STAY IN BALTIMORE <b>26--</b> Yrs. Mos. Days			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>		8. DATE OF BIRTH <b>Mar. 24, 1888</b>	9. AGE (In years last birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. City Schools</b>		11. BIRTHPLACE (State or foreign country) <b>N. Y.</b>	
12. CITIZEN OF WHAT COUNTRY? _____		13. FATHER'S NAME <b>John Treherne</b>			
14. MOTHER'S MAIDEN NAME <b>Not Known</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) _____			
16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <b>Harry J. Treherne, Jr. 1605 N. Longwood St.</b>			

18. <b>781X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of bladder</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		CERTIFICATION APPROVED BY <b>R. H. Fisher</b> M. D. CHIEF OR ASST. MEDICAL EXAMINER.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <b>head on arrival 7/17</b> , 19 <b>50</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:17 a. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Maurice E. Shaner</b> M. D.		23B. ADDRESS <b>3300 W. North Ave.</b>		23C. DATE SIGNED <b>7/18/1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-19-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>		
DATE RECEIVED BY <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>G. Howard Strong 3207 W. North Ave.,</b>	



M244  
50 6274

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6274  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>CELESTE V. McCLELLAN</b>			2. DATE OF DEATH <b>7-18-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>—</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 9-03</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>3514 ELLERSLIE AVE</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG. 15, 1857</b>	9. AGE (In years, last birthday) <b>92</b>	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			13. FATHER'S NAME <b>W. M. WARREN</b>		
14. MOTHER'S MAIDEN NAME <b>MARY JANE HARBAUGH</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>		
16. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT ADDRESS <b>J. WARREN McCLELLAN 319 E 334 St.</b>		

18. <b>E903.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL VASCULAR Acc</b> DUE TO <b>GEN'L. ARTERIOSCLEROSIS</b> DUE TO <b>HYPERTENSION</b>		INTERVAL BETWEEN ONSET AND DEATH
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>6-2</b>		19B. MAJOR FINDINGS OF OPERATION <b>FRACT. RIGHT FEMUR</b>
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>Accident</b>	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>3514 Ellerslie Avenue</b>
21D. TIME (Month) (Day) (Year) (Hour) <b>May 31, 1950 5:15 P. m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>
21F. HOW DID INJURY OCCUR? <b>Floor - SAME LEVEL</b>		<b>Slipped and fell to cellar floor</b>

22. I hereby certify that I attended the deceased from **7-1-50**, 19**50**, to **7-17-50**, 19**50**, that I last saw the deceased alive on **7-17-50**, 19**50**, and that death occurred at **10:45 P. m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>John F. Strahan</b>		23B. ADDRESS <b>University Hosp</b>		23C. DATE SIGNED <b>7-17-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-20-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>		25. FUNERAL DIRECTOR <b>G. Howard Strong</b>		ADDRESS <b>3207 W. North Ave.,</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. Williams</b>			





# FURNISS

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 50 6275

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

*Ronald W. Furniss*

2. DATE  
OF  
DEATH

*7/17/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

*UNIVERSITY HOSP.*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

*MARYLAND*

*Wicomico*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*SALISBURY*

D. STREET ADDRESS (If rural, give location)

*613 BUENA VISTA*

*7212*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year

If Under 24 Hours

*M*

*W*

*SINGLE*

*DEC. 3, 1943*

*6 YRS*

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

*NEVER WORKED*

11. BIRTHPLACE (State or foreign country)

*SALISBURY, MD*

12. CITIZEN OF WHAT COUNTRY?

*U. S. A.*

13. FATHER'S NAME

*DICK FURNISS*

14. MOTHER'S MAIDEN NAME

*MARGARET BROWN*

613 BUENA VISTA -

*SALISBURY, MD*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Hospital Records -*

18. *204.0*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) *Massive gastroduodenal hemorrhage.*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) *Idiopathic leukemia.*

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *7/14*, 19*50*, to *7/17*, 19*50*, that I last saw the deceased alive on *7/17*, 19*50*, and that death occurred at *11:45* p.m., from the causes and on the date stated above.

23A. SIGNATURE

*J. E. Furman*

M. D.

23B. ADDRESS

*University Hospital*

23C. DATE SIGNED

*7/18*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

*Burial*

*7-20-50*

*Wicomico Mem. Park*

*Salisbury, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*11 18 1950*

*William H. Williams, M.D.*

*Hill Johnson*

*Salisbury, Md.*



523

50

6276

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6276

1. NAME OF DECEASED (Type or Print) <b>CLAIRE Curtis C. Winston</b>		2. DATE OF DEATH <b>July 15, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>13 Yrs.</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>40 N. Caroline Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3/15/1914</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>36</b>
13. FATHER'S NAME <b>Thomas Winston</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Lula Keith</b>	
17. INFORMANT <b>Solomon S. Curtis</b>		ADDRESS <b>40 n. Carolina</b>	

18. <b>022X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Syphilitic aortitis with dissecting aneurysm of thoracic aorta</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Autopsy</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
23A. SIGNATURE <i>R. S. Fisher</i>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>July 15, 1950</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/18/1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Brooklyn A.A. Co. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <i>Huntington Williams, M.D.</i>	
25. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>		ADDRESS <b>1000 Brantly Ave.</b>	

STATE OF OHIO

IN SENATE

January 1, 1900

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE

FOR THE YEAR

1899

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APRIL

1898

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APRIL

1898

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452  
50 6277BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6277  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Estelle Wilkerson William S.</b>		2. DATE OF DEATH <b>July 15, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>901 Bennett Place</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 18-01</b>	
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>901 Bennett Place.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, <u>DIVORCED</u> (Specify)	8. DATE OF BIRTH <b>Dec. 13, 1903</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>46</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Francis Miller</b>		ADDRESS <b>1022 W. Saratoga</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral accident</b> DUE TO (A) <b>Cerebral accident</b> DUE TO (B) <b>Hypertensive cardiovascular disease</b> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks for first attack and 4 days for second.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 26, 1950</b> , to <b>July 15, 1950</b> , that I last saw the deceased alive on <b>July 14, 1950</b> , and that death occurred at <b>10:45 a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>C.R. Campbell</b>		23B. ADDRESS <b>718 Dolphin St.</b>		23C. DATE SIGNED <b>July 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-18-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Wm. A. Clark Co. Balto.</b>	
24D. LOCATION (City, town, or county) <b>Md.</b>		24E. STATE <b>Md.</b>		24F. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>	
REGISTRAR'S SIGNATURE <b>Timothy W. Williams</b>		25. FUNERAL DIRECTOR <b>Wm. R. Williams</b>		ADDRESS <b>322</b>	

ESTELLE WILKINSON  
1800 1/2  
100 X 75  
FUND  
CONGREGATION  
WATER  
1800 1/2  
100 X 75  
FUND  
CONGREGATION  
WATER



653  
REA-139462BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6278  
Registered No.

BIRTH NO. 50 6278

1. NAME OF DECEASED (Type or Print) <b>Ida Arnett</b>			2. DATE OF DEATH <b>July 16, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>14-03</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>42 yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>2217 Druid Hill Avenue</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 15, 1896</b>	9. AGE (in years last birthday) <b>53</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Harvey Washington</b>			14. MOTHER'S MAIDEN NAME <b>Sally French</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Avenue</b>		

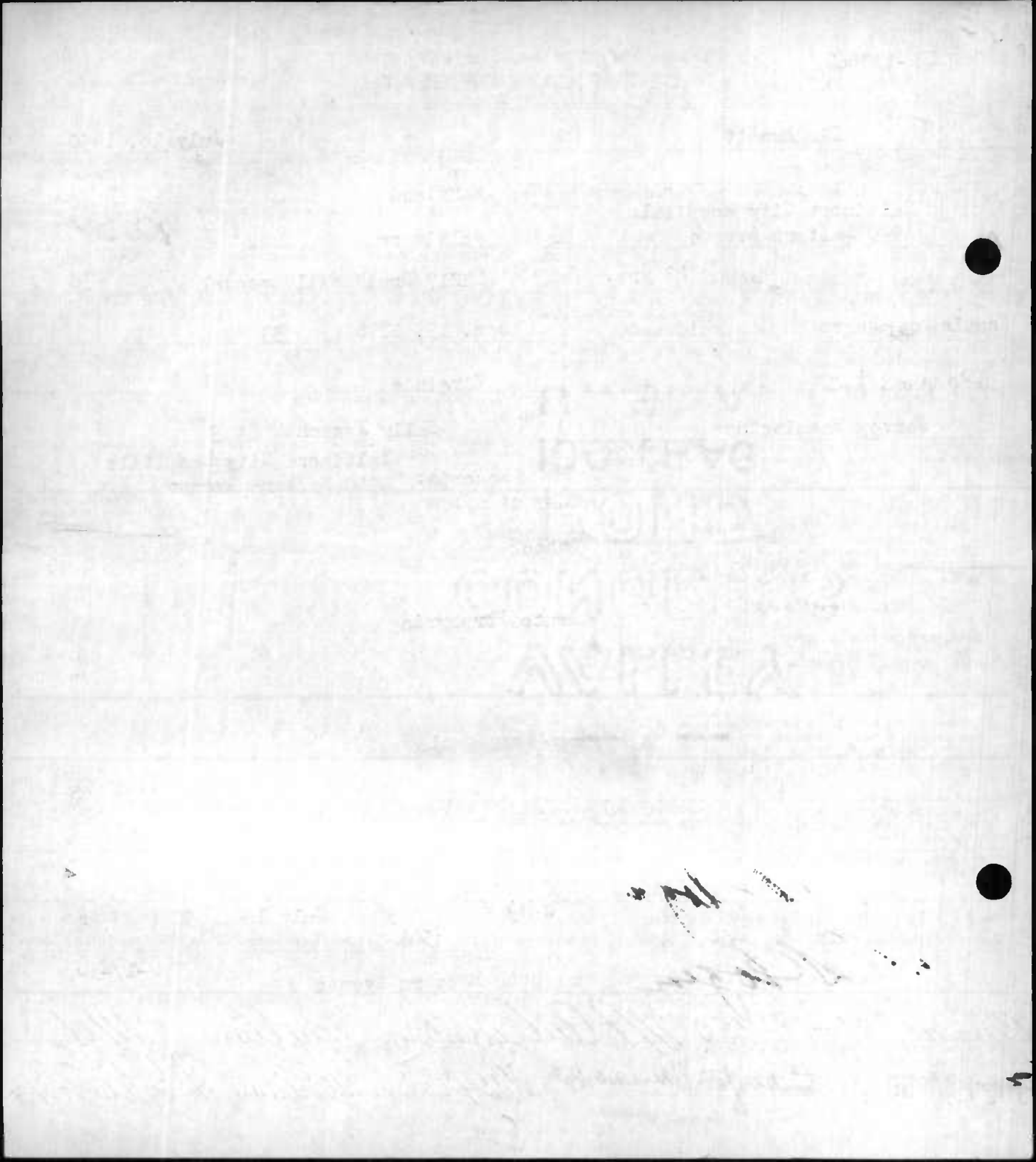
1B. <b>289.2</b>	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Shock</b>	
ANTECEDENT CAUSES		(B) <b>Acute Porphyria</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Acute Porphyria</b>			

19A. DATE OF OPERATION <b>7-19-1950</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 5, 1950</b> , to <b>July 16, 1950</b> , that I last saw the deceased alive on <b>July 16, 1950</b> , and that death occurred at <b>9:50A.M.</b> , from the causes and on the date stated above.				
23A. SIGNATURE <b>[Signature]</b>		23B. ADDRESS M. D. <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>7-17-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-19-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>W. H. Anderson Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. Robert Williams</b> ADDRESS <b>322 N. Schomberg St.</b>

7208A 277

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100

Love

50 6279

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50 6279

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

a. Baltimore City, Maryland

b. FULL NAME OF (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18. 570.2

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1 1950, to 7/14 1950, that I last saw the deceased alive on 7/14 1950, and that death occurred at 11:00 a. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

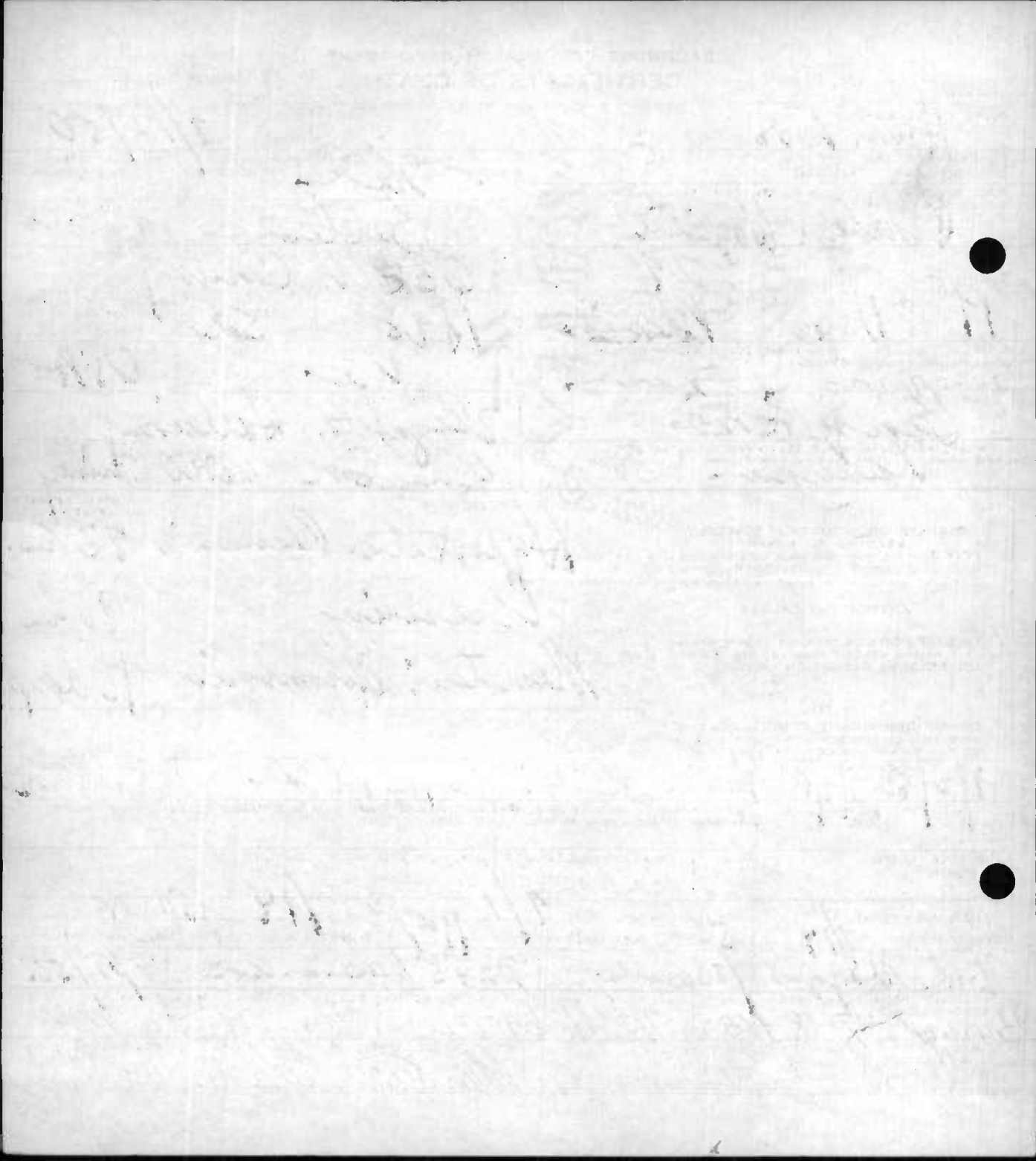
25. FUNERAL DIRECTOR

ADDRESS

9405578

123

MEDICAL CERTIFICATION

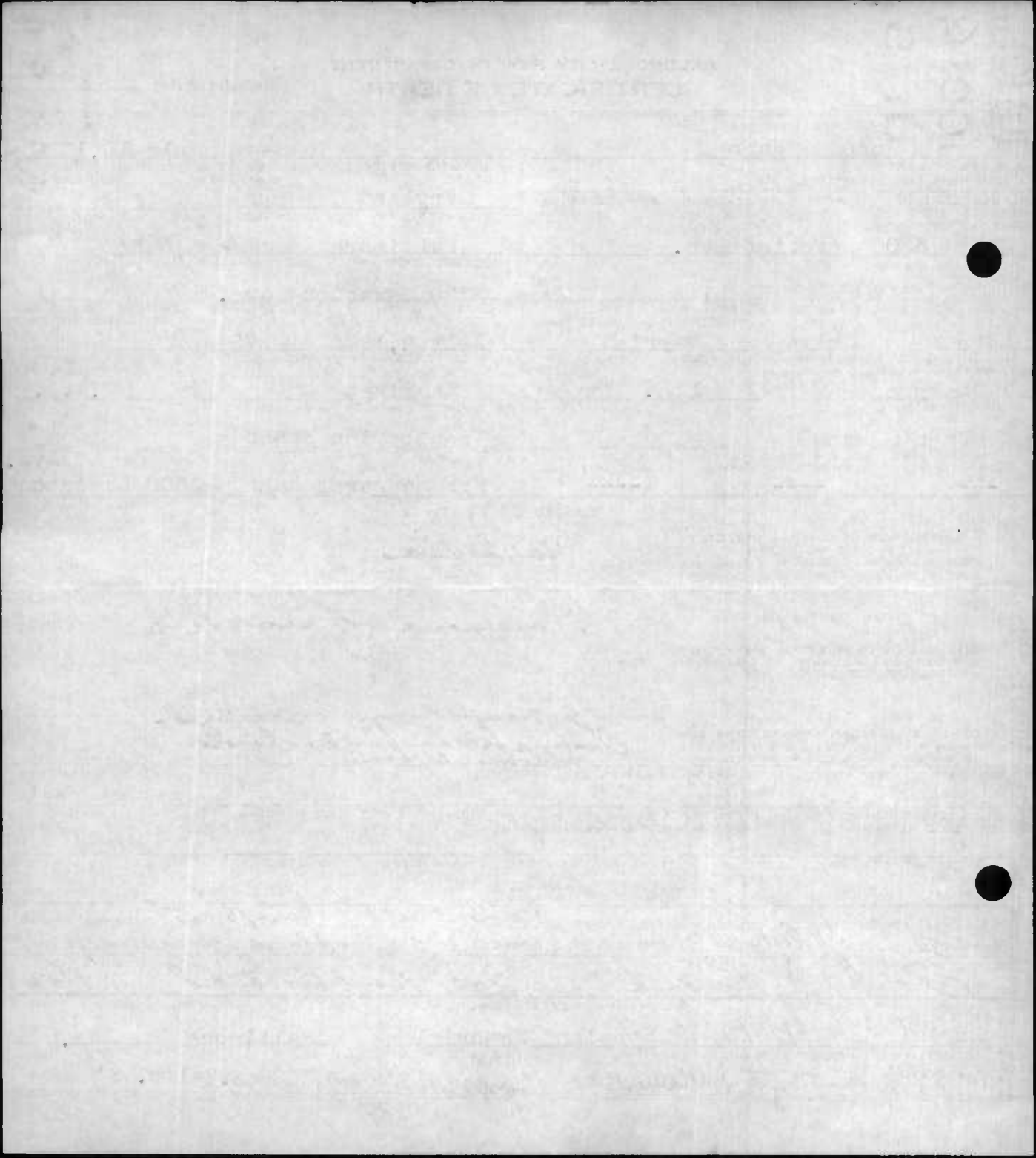


500  
0 6280BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6280

1. NAME OF DECEASED (Type or Print) John Hahn			2. DATE OF DEATH July 16, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) 3360 Leverton Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-10		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) 3300 Leverton Ave.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 9, 1875	9. AGE (In years last birthday) 75	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME John Hahn			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -----			16. SOCIAL SECURITY NO. -----		
17. INFORMANT Mrs Margaret Hahn			ADDRESS Ave. 3300 Leverton		
18. 177X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH Cachexia  DUE TO  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  (B) ? Carcinoma of prostate  (C) Intertrigo, generalized Fistula between bladder & lower abdominal wall			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from July 3, 1950, to July 16, 1950, that I last saw the deceased alive on July 16, 1950, and that death occurred at 11 A.M., from the causes and on the date stated above.					
23A. SIGNATURE Charles J. Black			23B. ADDRESS 2008 Randewood Rd		
23C. DATE SIGNED 7/17/50			23D. DATE SIGNED		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 7/20/50		
24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial			24D. LOCATION (City, town, or county) (State) Baltimore Md.		
DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1950			REGISTRAR'S SIGNATURE Wm. H. Williams, M.D.		
25. FUNERAL DIRECTOR John A. Moran			ADDRESS 3000 E. Balto. St		

MEDICAL CERTIFICATION

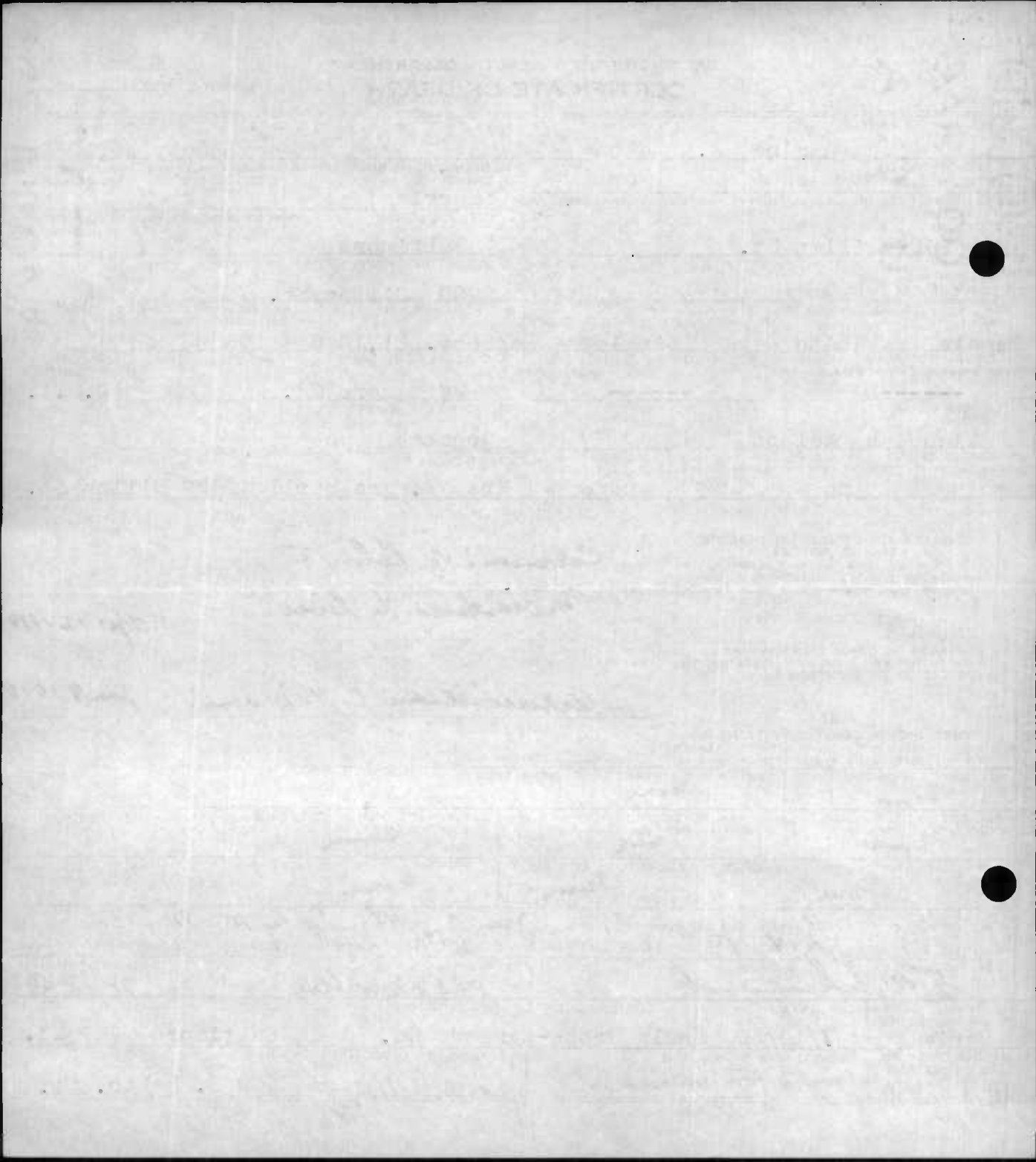




450  
50 6281BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6281

1. NAME OF DECEASED (Type or Print) Katherine A. Malone		2. DATE OF DEATH July 15, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2929 Dillon St.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-01	
D. STREET ADDRESS (If rural, give location) 2929 Dillon St.			
c. Length of stay in Baltimore Life		Yrs. Mos. Days	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Sept. 21, 1875 75 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Nicholas Malone		14. MOTHER'S MAIDEN NAME Johanna Lycette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Teresa Marll		ADDRESS 2929 Dillon St.	
18. 153X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Circumference of Colon & Metastases to liver. (B) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) Arteriosclerosis C. V. System. INTERVAL BETWEEN ONSET AND DEATH Apr 12 1950 Jan 9 1948			
19A. DATE OF OPERATION 2mm		19B. MAJOR FINDINGS OF OPERATION none	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 2mm		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 2mm	
21C. WHERE DID INJURY OCCUR? 2mm		21D. TIME (Month) (Day) (Year) (Hour) INJURY 2mm	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 2mm	
22. I hereby certify that I attended the deceased from Jan 9, 1948, to July 15, 1950, that I last saw the deceased alive on July 14, 1950, and that death occurred at 6:45 a.m., from the causes and on the date stated above.			
23A. SIGNATURE J. A. Schenck		23B. ADDRESS 842 E. E. Ave	
23C. DATE SIGNED 7-18-50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/50	
24C. NAME OF CEMETERY OR CREMATORY Holy Cross-Harford Rd.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1950		REGISTRAR'S SIGNATURE Livingston Williams, M.D.	
25. FUNERAL DIRECTOR John A. Moran		ADDRESS 3000 E. Balto. St.	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6282**

**620**  
**6282**  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Wm J. Freeze SR.</i>		2. DATE OF DEATH <i>7/12/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <i>MD</i> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>2734 RIGGS AVE.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore MD 16-07</i>	
6. Length of stay in Baltimore <i>LIFE</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>2734 RIGGS AVE</i>	
7. SEX <i>17</i>	8. COLOR OR RACE <i>W</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	10. DATE OF BIRTH <i>MAY 17 1880</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>BARTLETT HAYWARD (KOPPERS CO)</i>	9. AGE (In years last birthday) Months: Days <i>70</i>
11. FATHER'S NAME <i>THOMAS B. FREEZE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. MOTHER'S MAIDEN NAME <i>MARGARET SWANN.</i>		14. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>312-07-9915</i>	
17. INFORMANT <i>M. KATHERINE FREEZE</i>		ADDRESS <i>2734 RIGGS AVE</i>	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Chronic Disease</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATABLE TO THE DISEASE OR CONDITION CAUSING IT. DUE TO		INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>7/12/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an *Inspection* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>C. J. Culbreth</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input checked="" type="checkbox"/> M.D. <i>2/12/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>JULY 20 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>NEW CATHARAL CEM</i>	24D. LOCATION (City, town, or county) (State) <i>FREDERICK ROAD MD</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 18 1950</i>		REGISTRAR'S SIGNATURE <i>Wm J. Williams</i>	
25. FUNERAL DIRECTOR <i>Duffel Bros</i>		ADDRESS <i>1800 E LOMBARD ST</i>	

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6283**

**160**  
BIRTH NO. **50 6283**

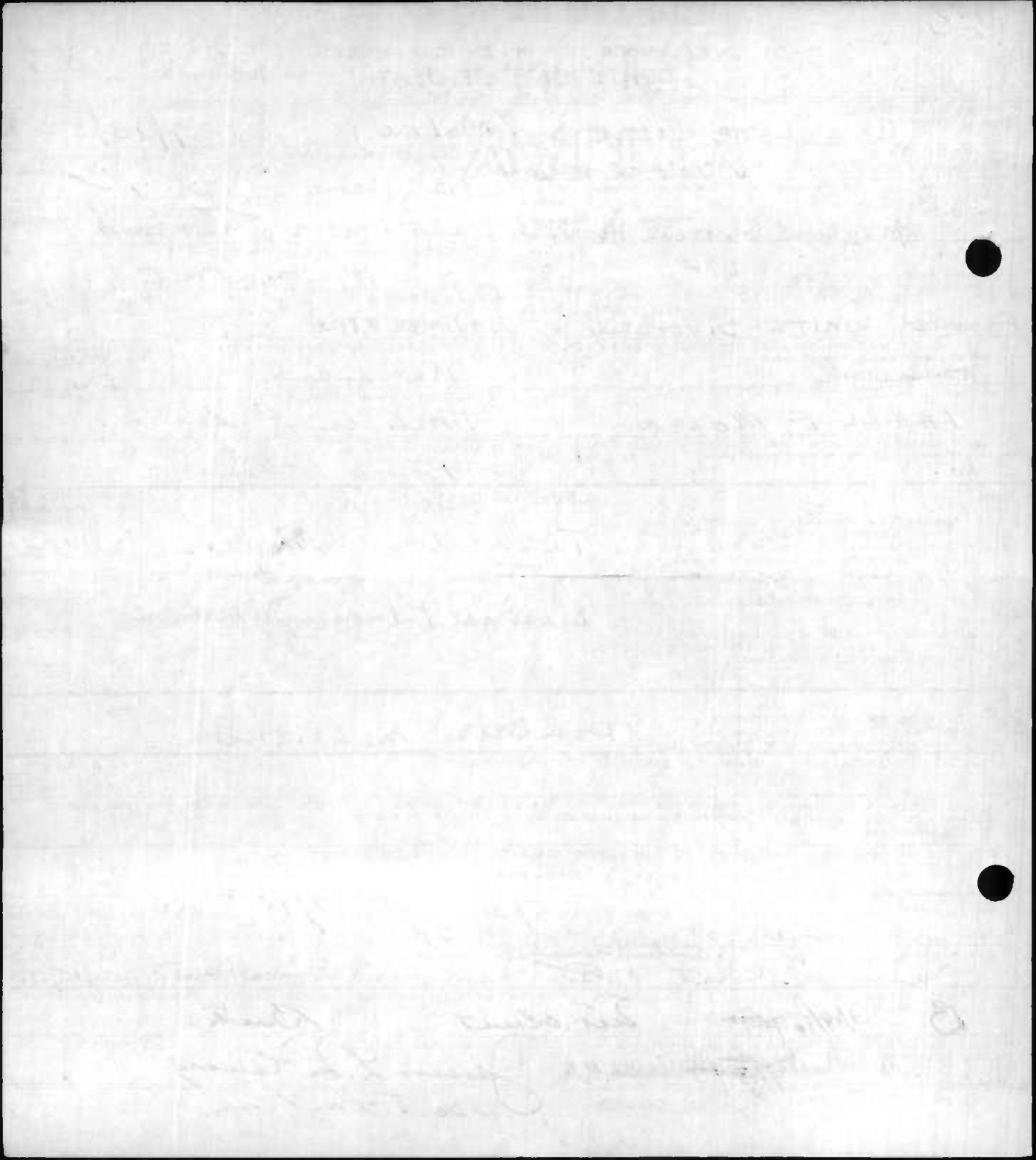
1. NAME OF DECEASED (Type or Print) <b>Charlotte Weber (Molex)</b>			2. DATE OF DEATH <b>7/15/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Maryland General Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <b>Maryland</b> B. COUNTY <b>23-06</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore, Maryland</b>		
C. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>30 E. Heath Street</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>November 8, 1922</b>		9. AGE (In years last birthday) <b>27</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>EARLE F. MOLEX</b>			14. MOTHER'S MAIDEN NAME <b>Thelma R. Lousay</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Family Samz.</b>			ADDRESS		

18. <b>002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Tuberculous meningitis</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B) Bilateral Pulmonary Tuberculosis</b> DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>(C) Diabetic mellitus</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5/31/50</b> , 19 <b>50</b> , to <b>7/15</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 15</b> , 19 <b>50</b> , and that death occurred at <b>2 P. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Mary W. Clift</b>		23B. ADDRESS <b>Maryland General Hospital</b>		23C. DATE SIGNED <b>July 15, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>B</b>		24B. DATE <b>7/19/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>W. Olmsted</b>		24D. LOCATION (City, town, or county) (State) <b>Balt.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		REGISTRAR'S SIGNATURE <b>William H. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>James L. Deaney</b>		ADDRESS <b>130 E. Heath St.</b>	

MEDICAL CERTIFICATION





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6284

1. NAME OF DECEASED (Type or Print) <i>John Thompson</i>			2. DATE OF DEATH <i>7-15-50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Crown Cork &amp; Seal Co</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE _____ B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Crown Cork &amp; Seal Co.</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto. Md.</i>		
C. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>2307 Foster Ave</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>2-4-03</i>	9. AGE (In years last birthday) <i>47</i>	<i>11 Under 1 Year Months: Days</i> <i>11 Under 24 Hours Hours: Min.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mach. Operator</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Crown Cork Co.</i>		
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Leander J. Thompson</i>			14. MOTHER'S MAIDEN NAME <i>Mary C. Tierney</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Julia Thompson wife-2307 Foster Ave</i>			ADDRESS		

18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Coronary Sclerosis with occlusion.</i>	CAUSE OF DEATH (A) _____ DUE TO (B) _____ DUE TO (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>No Injury</i>	
22. I certify that I took charge of the remains described above, held an <i>Autopsy</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>R. F. Fisher</i>		23B. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <i>7-16-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-20-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel</i>	
				24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	

DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 18 1950</i>		REGISTRAR'S SIGNATURE <i>Henrietta Williams</i>		25. FUNERAL DIRECTOR <i>Lilly &amp; Zeiler, 403 S. Wolfe Street</i>	
VS 151		54432		94a	

CERTIFICATE OF DEATH

John Thompson

John Thompson

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6285

BALTIMORE CITY HEALTH DEPT.  
CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Mrs. Augusta Horvath</i>		2. DATE OF DEATH <i>7-17-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Doctors Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Doctors Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>1-23</i>	
D. STREET ADDRESS (If rural, give location) <i>718 S. Rose St.</i>		5. SEX <i>FEMALE</i> 6. COLOR OR RACE <i>WHITE</i> 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	
c. Length of stay in Baltimore		8. DATE OF BIRTH <i>DEC. 15, 1892</i> 9. AGE (In years last birthday) <i>57</i> 11 Under 1 Year Months: Days 11 Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WORK</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>	
13. FATHER'S NAME <i>FRANK MURAWSKI</i>		14. MOTHER'S MAIDEN NAME <i>ANTONINA DOYAS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>JOSEPH HORVATH JR</i>		ADDRESS <i>5203 EASTERN AVE</i>	

18. <i>561.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardiovascular Disease</i>		CAUSE OF DEATH	
ANTECEDENT CAUSES		(A) DUE TO <i>Strangulated Umbilical Hernia</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO <i>Intestinal Obstruction</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C) <i>Diabetes Mellitus</i>	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/11</i> , 19 <i>50</i> , to <i>7/16</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7/16</i> , 19 <i>50</i> , and that death occurred at <i>715</i> <i>Am.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>William J. Secourski</i> M. D.		23B. ADDRESS <i>3711 Eastern Ave</i>		23C. DATE SIGNED <i>7/19/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>7-19-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>PARK WOOD CEM.</i>	
24D. LOCATION (City, town, or county) <i>TAYLOR AV. BALTO. CO.</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 18 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm. J. Secourski</i>	
24G. FUNERAL DIRECTOR <i>Charles S. Gailer</i>		24H. ADDRESS <i>901 S. CONKLINGS</i>		24I. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 18 1950</i>	

DEPARTMENT

Registered No.

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6285

1450

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6286

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6286

1. NAME OF DECEASED (Type or Print) <b>Edward J. Hayes</b>		2. DATE OF DEATH <b>7-18-1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1509 Ensor St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 9-09</b>	
c. Length of stay in Baltimore <b>66</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1509 Ensor St. City</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 27, 1889</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman, Baltimore City Water Dept.</b>		9. AGE (In years last birthday) <b>66</b>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>	
13. FATHER'S NAME <b>John Hayes</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>Nora Deegan</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Margaret M. Hayes</b> ADDRESS <b>1509 Ensor St.</b>	
18. <b>442 X</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Inter cerebral Cerebral Vascular</b>	
DUE TO		<b>Renal Disease</b>	
ANTECEDENT CAUSES		(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO	
II		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 15, 1950</b> , to <b>July 8, 1950</b> , that I last saw the deceased alive on <b>7/17, 1950</b> , and that death occurred at <b>3:45 Am.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Ernest S. Blum</b> M. D.		23B. ADDRESS <b>1145 N. Calver St.</b>	
23C. DATE SIGNED <b>7/18/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-21-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>	REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Elmer W. Conklin</b> ADDRESS <b>924 E. Eager St.</b>	

MEDICAL CERTIFICATION

523 5F

121a

R.R. - 13km  
1115-91. Galant AF.



500

0 6287

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6287

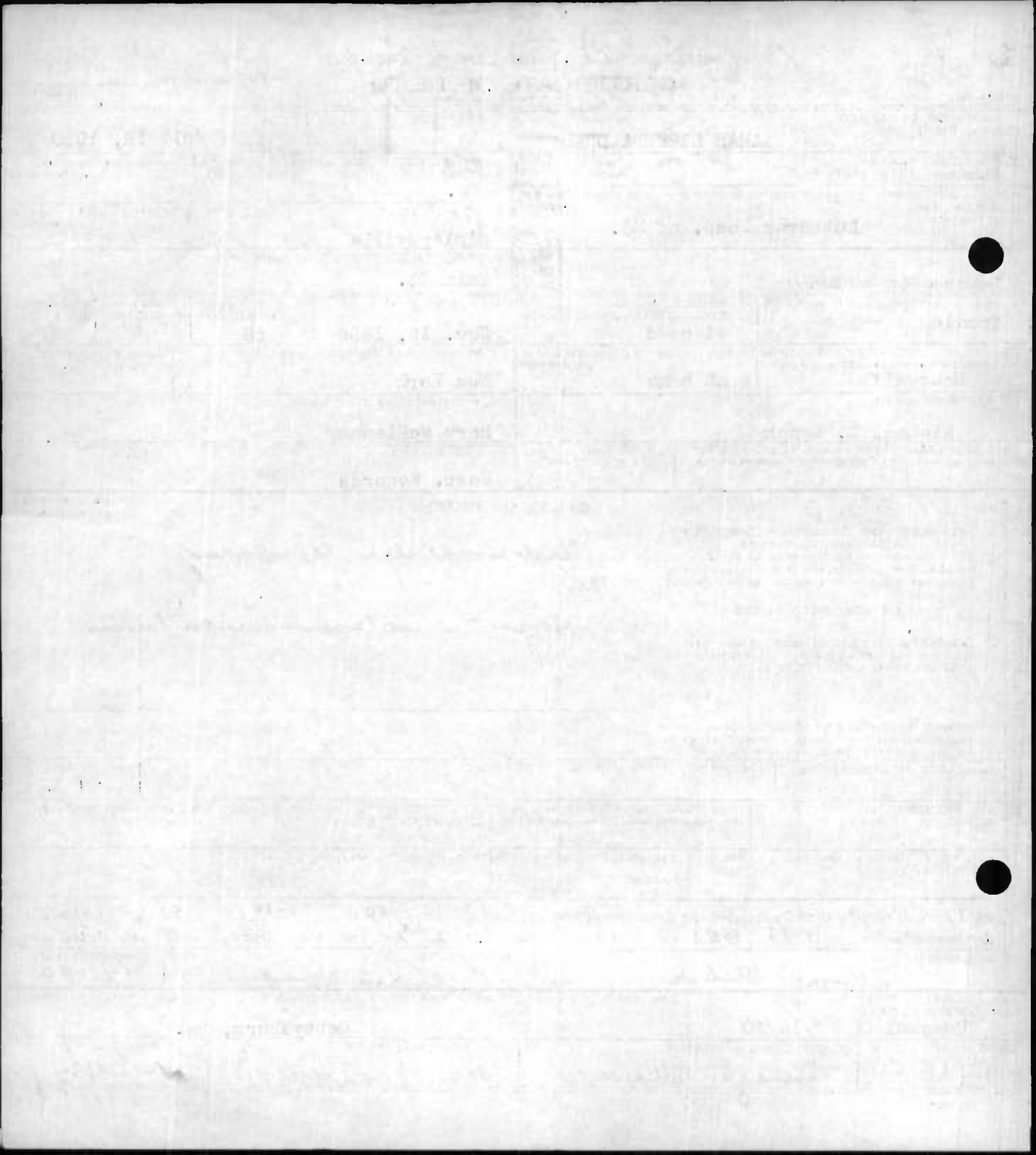
Registered No.

BIRTH NO.		2. DATE OF DEATH July 18, 1950	
1. NAME OF DECEASED (Type or Print) SARAH LORETTA DUNN			
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY V-35	
B. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hosp. of Md.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Biglersville	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) Main St.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Nov. 19, 1899
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (in years last birthday) 50
13. FATHER'S NAME Michael T. Lynch		11. BIRTHPLACE (State or foreign country) New York	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME Mary McElenney	
17. INFORMANT Hosp. Records		ADDRESS	

18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DUE TO (A) Cerebrovascular hemorrhage	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) Hypertensive Cardiovascular Disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C)		

19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 7-17, 1950, to 7-18, 1950, that I last saw the deceased alive on 7-18, 1950, and that death occurred at 12:05 Am., from the causes and on the date stated above.		
23A. SIGNATURE Jerome Gaber	23B. ADDRESS Lutheran Hosp. M. D.	23C. DATE SIGNED 7-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 7/18/50	24C. NAME OF CEMETERY OR CREMATORY Gettysburg, Pa.	24D. LOCATION (City, town, or county) (State)
DATE RECEIVED BY LOCAL REGISTRAR JUL 18 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Thos. J. Pickner & Sons - Balt.	ADDRESS Md.



160

50 6288

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6288

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES A. HOOPER

2. DATE  
OF  
DEATH

July 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

6028 Old Harford Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Joseph Hooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6028 Old Harford Rd.

8. DATE OF BIRTH

Dec. 15, 1873

9. AGE (in year-  
last birthday)

76

11 Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Anastasia Knox

17. INFORMANT

ADDRESS St.

Mrs. Estelle Gutberlet - 1335 Homestead

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) *aneurysm of abdominal aorta*  
DUE TO

10 YRS

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) *arteriosclerosis*  
DUE TO

10 YRS

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

1942

*aneurysm of abdominal aorta*YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

INJURY

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

22. I hereby certify that I attended the deceased from June 5, 1950, to July 17, 1950, that I last saw the deceased alive on July 15, 1950, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Lloyd E. Saylor*

M. D.

*3902 Greenmount Ave**July 17, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/19/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 18 1950

*Thurston Williams, Jr.**Thm. J. Lickner & Sons - Balt.*

VS 150

96

VALLEY

CONGRESS

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6289

400  
BIRTH NO. 50 6289

1. NAME OF DECEASED (Type or Print) <b>ROBERT M. HILL</b>			2. DATE OF DEATH <b>July 17, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>4118 Newbern</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>4118 Newbern</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Dec. 11, 1929</b>	9. AGE (In years last birthday) <b>20</b>	10. Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never worked</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Charles C. Hill</b>			14. MOTHER'S MAIDEN NAME <b>Genevieve Evans</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>- XXX</b>	17. INFORMANT ADDRESS <b>Mr. Charles C Hill - 4118 Newbern</b>		

18. <u>490X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Lobar Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Chronic Pneumonia</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Pericarditis</b>			
19A. DATE OF OPERATION <b>no operation</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)			21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. HOW DID INJURY OCCUR?
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>March 8, 1950</u> , to <u>July 17, 1950</u> , that I last saw the deceased alive on <u>July 16, 1950</u> and that death occurred at <u>m.</u> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Joshua H. Armacoet</b>		23B. ADDRESS <b>6419 Woodson Hill Rd</b>	
23C. DATE SIGNED <b>July 18, 1950</b>		23D. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>July 18 1950</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Siskner &amp; Sons Balt Md</b>	

UNITED STATES OF AMERICA  
DEPARTMENT OF JUSTICE

INVESTIGATION OF THE  
ACTS OF VIOLENCE  
COMMITTED BY THE  
BLACK PANTHER PARTY  
IN THE CITY OF  
SAN FRANCISCO  
DURING THE  
PERIOD FROM  
JANUARY 1, 1968  
TO JANUARY 1, 1969

REPORT OF THE  
FEDERAL BUREAU OF INVESTIGATION  
ON THE ACTS OF VIOLENCE  
COMMITTED BY THE  
BLACK PANTHER PARTY  
IN THE CITY OF  
SAN FRANCISCO  
DURING THE  
PERIOD FROM  
JANUARY 1, 1968  
TO JANUARY 1, 1969

BY  
SPECIAL AGENT IN CHARGE  
JAMES EARL RAY  
JANUARY 1, 1969



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6290

Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Joseph Cogilandro</b>			2. DATE OF DEATH <b>July 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1415 Mosander Way</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>X</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>26-06</b>		
c. Length of stay in Baltimore 7 Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>1415 Mosander Way</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>December 15, 1889</b>		9. AGE (in years last birthday) <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Keeper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retail TAVERN</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>Joseph known</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Grace Cogilandro 1415 Mosander Way</b>	

18. <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma stomach</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>June 1, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma stomach</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>the</b> <b>1946</b> , to <b>July 18, 1950</b> , that I last saw the deceased alive on <b>July 17, 1950</b> , and that death occurred at <b>6.3</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>David N. Andrews</b>		23B. ADDRESS <b>2 Hunsley Rd Woodlawn Md</b>		23C. DATE SIGNED <b>July 18, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>Mother of Sorrow</b>	
24D. LOCATION (City, town, or county) (State) <b>Carbendal Pennsylvania</b>		24E. REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		24F. FUNERAL DIRECTOR <b>John E. Goff</b>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 18 1950</b>		24H. ADDRESS <b>Chase, Md.</b>			

MEDICAL CERTIFICATION

July 18, 1850

Joseph C. Lander  
145 Massachusetts

1850

Belmont

145 Massachusetts

Belmont, Mass. 60

July

Belmont

Joseph C. Lander

1850

July

Belmont

Belmont

Belmont

1850

Belmont

July 18, 1850

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6291  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Rosa Alexander</u>		2. DATE OF DEATH <u>July 17, 1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Washington</u>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Highfield</u>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>7100</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-8-82</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>68</u>
11. BIRTHPLACE (State or foreign country) <u>Middletown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u>		ADDRESS	

18. <u>253x</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Hypothyroidism</u> DUE TO _____		<u>1 yr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>7-17-50</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>6-8</u> , 19 <u>50</u> , to <u>7-17</u> , 19 <u>50</u> that I last saw the deceased alive on <u>7-17</u> , 19 <u>50</u> and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.				
23A. SIGNATURE <u>Joseph Stokes M. D.</u>		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-20-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Middletown Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 19 1950</u>	REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>Highfield Co.</u>	

TABLE 20. 1971-72

Grain and Grain Products, 1971-72

UNIT: 1000 METRIC TONS

1. Total grain and grain products

2. Wheat and meslin

3. Barley

4. Oats

5. Rye

6. Corn

7. Sorghum

8. Millet

9. Other

10. Total

11. Total

12. Total

13. Total

14. Total

15. Total

16. Total

17. Total

18. Total

19. Total

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6292  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>ANNIE M. DERRENNBERGER</b>			2. DATE OF DEATH <b>July 17, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>West Baltimore General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>16-06</b>		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>2860 W. Lanvale Street</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>8-15-1865</b>		9. AGE (In years last birthday) <b>84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Frederick C. Abel</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Frank N. Stauffer, Walkersville, Md.</b>		

18. <b>4221</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>Arteriosclerotic cardiovascular disease</b>	INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO	
ANTECEDENT CAUSES	
(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>Stanley H. Dunlacker</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 17, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cew. Baltimore</b>	24D. LOCATION (City, town, or county) (State) <b>Md</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>		FURNERAL DIRECTOR <i>F. B. Shuppert, Son 1300 Eutaw Pl.</i>	
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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6293  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Ella Wiefenbach(Weifenbach)</b>		2. DATE OF DEATH <b>7/16/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>923 N. Patterson Pk Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 7-63</b>	
c. Length of stay in Baltimore <b>Life</b> Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>923 N. Patterson Pk Ave.,</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Nov 3, 1899</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife at home</b>		10B. KIND OF BUSINESS OR INDUSTRY _____	
13. FATHER'S NAME <b>Rudolph Bolard</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service) _____		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
16. SOCIAL SECURITY NO. <b>none</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
17. INFORMANT <b>John Wiefenbach(husband)</b>		ADDRESS <b>923 N. Patterson</b>	

18. **237 X I**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

**CAUSE OF DEATH**

(A) **Sty post. A. T. C. Pneumonia**  
DUE TO

(B) **Brain Tumor**  
DUE TO

(C) \_\_\_\_\_

INTERVAL BETWEEN ONSET AND DEATH  
**7/14/50**  
**1/15/49**  
**over**

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

**II**  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>April 23, 1950</b> to <b>July 16, 1950</b> , that I last saw the deceased alive on <b>July 15, 1950</b> , and that death occurred at <b>12:45 m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William J. Ryan</b>		23B. ADDRESS <b>801 N. Kenwood</b>		23C. DATE SIGNED <b>7/17/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/19/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
24D. LOCATION (City, town, or county) <b>Frederick Ave., Maryland.</b>		25. FUNERAL DIRECTOR <b>Schimunek Funeral Home 2601-5 E. Madison St.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		ADDRESS	

Nature of tumor unknown. Letter in document file 50-629.  
8/1/50.

365  
50 6294

LADERMAN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6294  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) *Hyman Sademann*

2. DATE OF DEATH *July 18, 1950*

3. PLACE OF DEATH  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *md.*  
B. COUNTY

5. SEX *Male*

6. COLOR OR RACE *White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *married*

8. DATE OF BIRTH *2-22-84*

9. AGE (In years last birthday) *66*

10. UNDER 1 Year Months: Days

11. UNDER 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *retired*

10B. KIND OF BUSINESS OR INDUSTRY *Fruit Dealer*

11. BIRTHPLACE (State or foreign country) *Russia*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME *Harry*

14. MOTHER'S MAIDEN NAME *Not known*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *No*

16. SOCIAL SECURITY NO.

17. INFORMANT *JOHNS HOPKINS HOSPITAL*

ADDRESS

18. *610X*

CAUSE OF DEATH.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH *10 min.*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) *Probable Cerebro-Vascular accident.*

(B) *Benign Prostatic Hypertrophy*

(C) *Post-operative oliguria & mild anemia*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *July 14, 1950*

19B. MAJOR FINDINGS OF OPERATION *Benign Prostatic Hypertrophy*

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7-11* 1950, to *7-18* 1950, that I last saw the deceased alive on *7-19* 1950, and that death occurred at *9:10 P.m.*, from the causes and on the date stated above.

23A. SIGNATURE *William E. Chase* M. O.

23B. ADDRESS *JOHNS HOPKINS HOSPITAL*

23C. DATE SIGNED *July 18, 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify) *Burial*

24B. DATE *7-19-50*

24C. NAME OF CEMETERY OR CREMATORY *Rosedale*

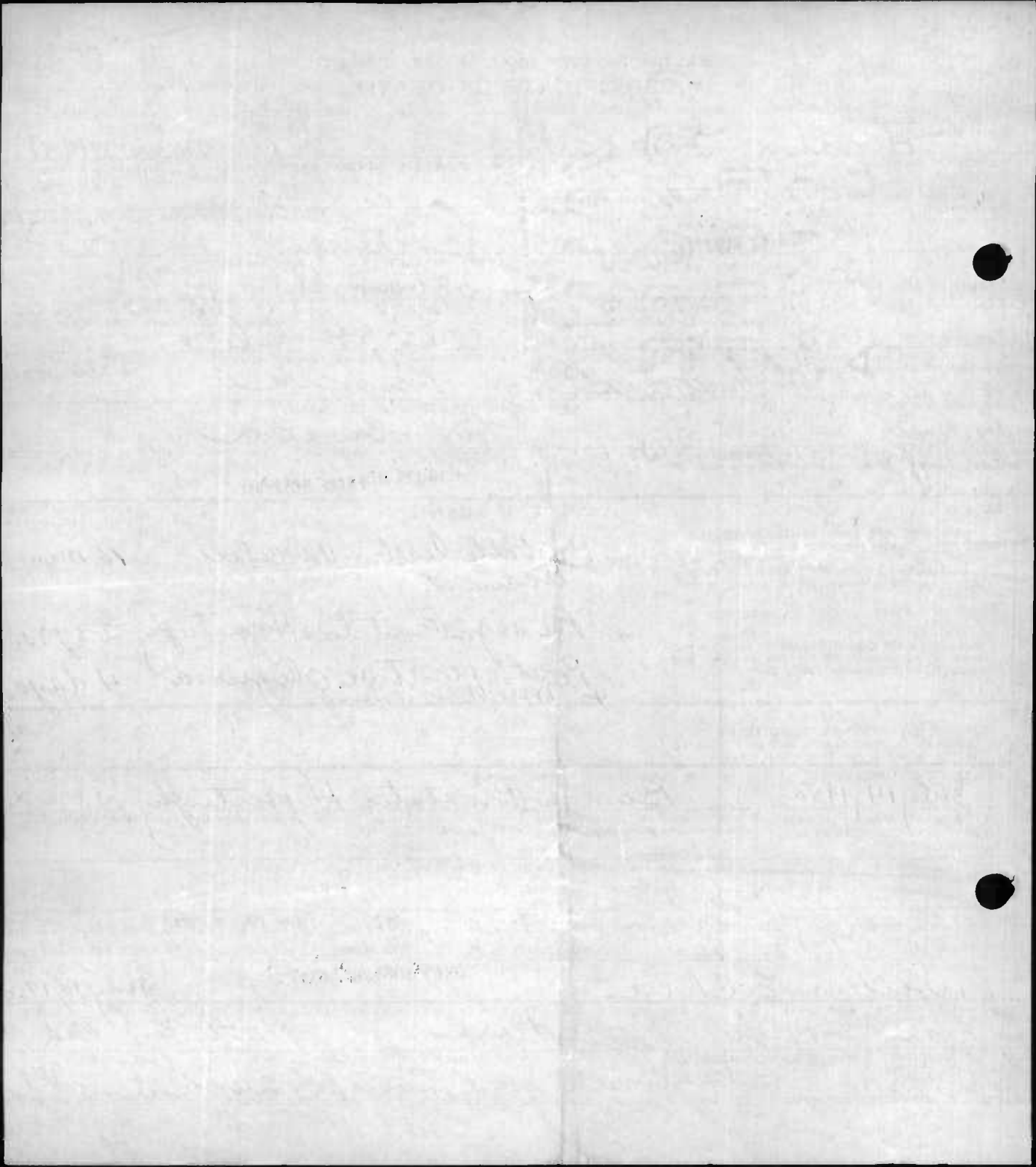
24D. LOCATION (City, town, or county) (State) *Balto Md.*

DATE RECEIVED BY LOCAL REGISTRAR *Jul 19 1950*

REGISTRAR'S SIGNATURE *Wilmington Williams*

25. FUNERAL DIRECTOR *Jack Lewis Inc*

ADDRESS *2100 Centard Pl*



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6295**

BIRTH NO. <b>325 50 6295</b>		2. DATE OF DEATH <b>7-18-50</b>	
1. NAME OF DECEASED (Type or Print) <b>YETTA KATZEN</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Howard</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Woodstock</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai</b>		D. STREET ADDRESS (If rural, give location) <b>6300</b>	
C. Length of stay in Baltimore <b>50</b> Yrs. Mos. Days		8. DATE OF BIRTH	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	9. AGE (In years last birthday) <b>65</b>	11. BIRTHPLACE (State or foreign country) <b>Lith</b>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Elliott</b>		14. MOTHER'S MAIDEN NAME <b>not known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Young Randay</b>		ADDRESS <b>1600 W Balto St</b>	
18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic heart disease</b> DUE TO <b>Hypertensive - c-v disease</b> DUE TO <b>Heart failure.</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-12-1950</b> to <b>7-18-1950</b> , that I last saw the deceased alive on <b>7-15-1950</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Henry C. Stephen</b>		23b. ADDRESS <b>Sinai Hospital</b>	23c. DATE SIGNED <b>7-18-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>7-19-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>	24D. LOCATION (City, town, or county) (State) <b>Balto, Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Jack Lewers</b>	
ADDRESS <b>2100 Eutaw Pl</b>			

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

WILLIAM J. HAYES





420

50 6296

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6296

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DOROTHY H. ALLEX

2. DATE  
OF  
DEATH

7-18-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4220 Norfolk Ave

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 28-03

D. STREET ADDRESS (If rural, give location)

4220 Norfolk Ave

E. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

9. AGE (In years last birthday)

10. Under 1 Year  
Months Days Hours Min.

48

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Levinson

14. MOTHER'S MAIDEN NAME

Kate Levinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

Yes, no or unknown

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Madore Allex - Same

18. 153X

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Carcinoma of colon

DUE TO

## ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

18 months

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

22. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from April 1950, to July 18, 1950, that I last saw the deceased alive on July 18, 1950, and that death occurred at 11:55 p. m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

Manuel Levin

4818 Rutherford Road

July 19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

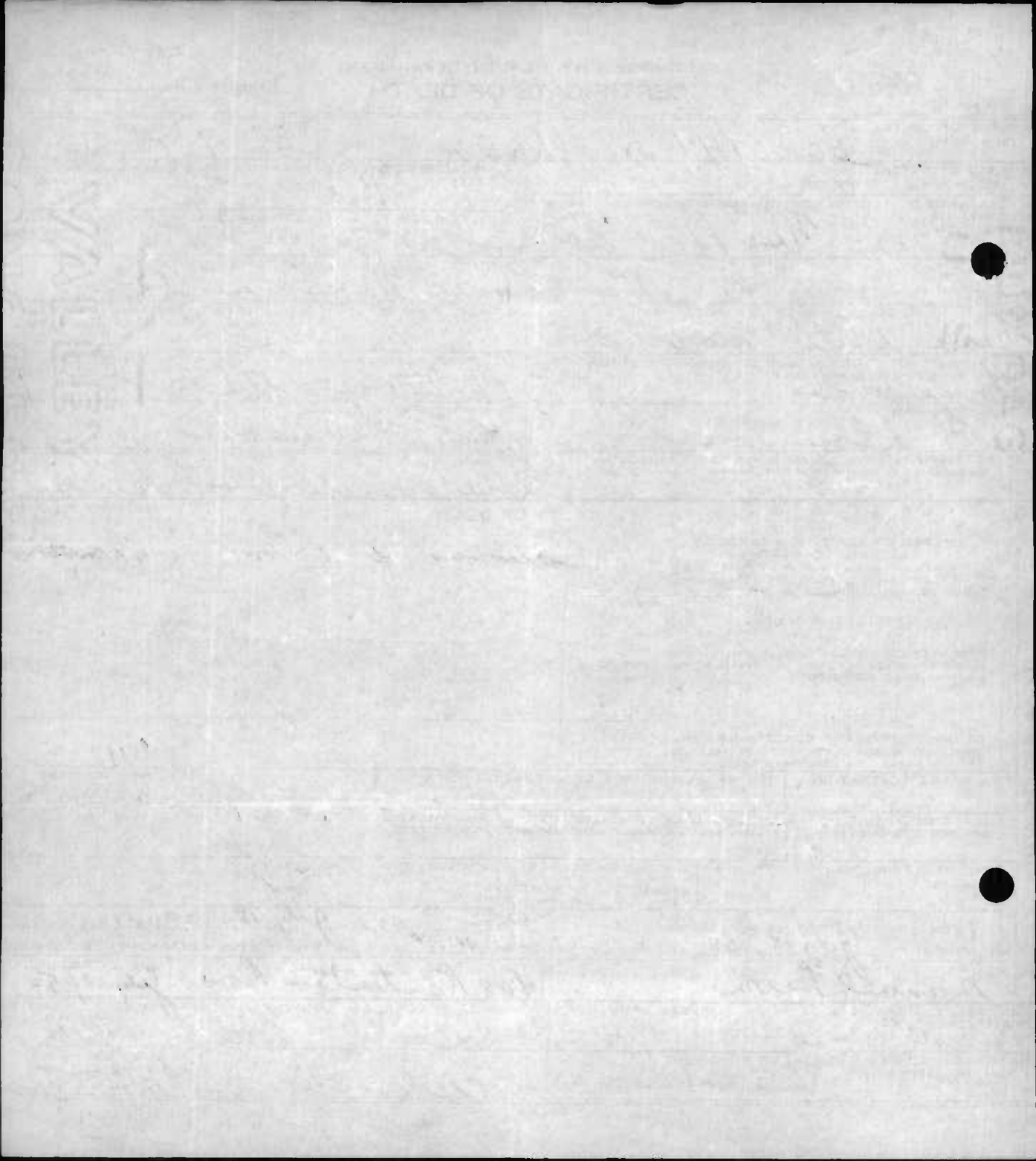
25. FUNERAL DIRECTOR

ADDRESS

III 191950

Wilmington Williams, M.D.

Jack Lewis, Inc. 2100 Euston Pl



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6297**

BIRTH NO. **636**

1. NAME OF DECEASED (Type or Print) <b>AMELIA MARGARET MEERDTER.</b>		2. DATE OF DEATH <b>July 18, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, in institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>The Hospital For the Women of Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 19-02</b>	
c. Length of stay in Baltimore <b>-</b>		d. STREET ADDRESS (If rural, give location) <b>1404 W. Lexington St.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>12-19-1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>76.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md -</b>	
13. FATHER'S NAME <b>John M. Meerdter</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>Fredericka? Manz.</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>L. H. REED - 1400 W. Lexington St.</b>	

18. <b>181X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Bladder.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Hypertension, left</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Psychitis, bilateral</b>		

19A. DATE OF OPERATION <b>7/1</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/1</b> , 19 <b>50</b> , to <b>7/18</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/17</b> , 19 <b>50</b> , and that death occurred at <b>12:30</b> A. M., from the causes and on the date stated above.					
23A. SIGNATURE <b>Mark E. Heltz, Jr.</b>		23B. ADDRESS <b>Wormers Hospital</b>		23C. DATE SIGNED <b>7/18/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 21-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, Jr.</b>		25. FUNERAL DIRECTOR <b>William Cook Inc.</b>		ADDRESS <b>1217 St. Paul St</b>	

STATE OF NEW YORK  
CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF CORONER	
DATE OF BIRTH		DATE OF DEATH		DATE OF BURIAL		DATE OF INTERMENT		DATE OF CREMATION		DATE OF REINTERMENT	
PLACE OF BIRTH		PLACE OF DEATH		PLACE OF BURIAL		PLACE OF INTERMENT		PLACE OF CREMATION		PLACE OF REINTERMENT	
CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF BURIAL		COUNTY OF BURIAL		STATE OF BURIAL	
CITY OF INTERMENT		COUNTY OF INTERMENT		STATE OF INTERMENT		CITY OF CREMATION		COUNTY OF CREMATION		STATE OF CREMATION	
CITY OF REINTERMENT		COUNTY OF REINTERMENT		STATE OF REINTERMENT		CITY OF CREMATION		COUNTY OF CREMATION		STATE OF CREMATION	

620

50 6298

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6298

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ALLEN B. CROUCH</b>		2. DATE OF DEATH <b>July 18, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>Balto. Md.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>—</b>			
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 12-01</b>			
c. Length of stay in Baltimore <b>78</b> Yrs. <input checked="" type="checkbox"/> Mos. <input checked="" type="checkbox"/> Days		d. STREET ADDRESS (If rural, give location) <b>3529 Newland Rd.</b>			
5. SEX <b>m</b>	6. COLOR OR RACE <b>w</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>—</b>		8. DATE OF BIRTH <b>Jan 5, 1872</b>	9. AGE (In years last birthday) <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>WILLIAM CROUCH</b>		14. MOTHER'S MAIDEN NAME <b>Isabella B. Chrismer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>—</b> ADDRESS <b>—</b>	

18. <b>451X</b> CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		
(A) <b>Hemorrhage from abdominal aneurysm</b>	DUE TO	<b>5 days</b>
(B) <b>Adynamic ileus</b>	DUE TO	<b>5 days</b>
(C) <b>Arteriosclerosis</b>		<b>(over)</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7/19/50</b>		19B. MAJOR FINDINGS OF OPERATION <b>—</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>—</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>			
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>—</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>—</b>			
22. I hereby certify that I attended the deceased from <b>July 10, 1950</b> to <b>July 18, 1950</b> that I last saw the deceased alive on <b>July 18, 1950</b> , and that death occurred at <b>7:25 AM</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Frank S. Kuehn</b> M. D.		23B. ADDRESS <b>Mercy Hospital</b>		23C. DATE SIGNED <b>July 18, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>H. H. Meares and Son, 805 N. Calvert St.</b>

was abdominal  
aneurysm due to  
arteriosclerosis

or  
of syphilitic origin?

"Aneurysm due to arteriosclerosis"

(not syphilitic) See Document File 50-629

8-24-50

20



2150 6299  
REA-139505BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6299  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Leslie Josephine

2. DATE  
OF  
DEATH

July 7, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTE Baltimore City Hospitals  
4940 Eastern Avenue4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE Maryland  
B. COUNTY

C. CITY OR TOWN

Baltimore

D. STREET ADDRESS (If rural, give location)

Crownsville State Hospital

C. Length of stay in Baltimore

?

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Negro

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

?

8. DATE OF BIRTH

7-7-1912

9. AGE (in years  
last birthday)

62 (?)

10. Under 1 Year  
Months: Days11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

? Unknown

14. MOTHER'S MAIDEN NAME

? Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Baltimore City Hospitals  
Records: 4940 Eastern Avenue

18.

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ventricular Fibrillation

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Intestinal Obstruction with Perforation

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 6, 1950 to July 7, 1950 that I last saw the deceased alive on July 7, 1950 and that death occurred at 1:15 A. M., from the causes and on the date stated above.

23A. SIGNATURE

W. E. Dozer

M. D.

23B. ADDRESS  
4940 Eastern Avenue

23C. DATE SIGNED

7-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL JUL 17 1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

JUL 19 1950

VS 150

122B

Address obtained from Balto. City Hcpts. 8/28/50.

6612  
M M 139223

50 6300

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6300

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Claude, Graves

2. DATE  
OF  
DEATH

June 26, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTIONBaltimore City Hospitals  
4940 Eastern Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Crownsville State Hospital

D. STREET ADDRESS (If rural, give location)

924 Denver St.

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)Yrs.  
Mos.  
Days

8. DATE OF BIRTH

1 1 1

9. AGE (in years  
last birthday)

39

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

B.C.N.

18. 153X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Shock

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE. (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Probable Perforated large bowel  
carcinoma with hemorrhage

(C)

INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-26-50, 19, to 6-26, 19 50, that I last saw the  
deceased alive on 6-26, 19 50 and that death occurred at 11:AM, from the causes and on the date stated above.

23A. SIGNATURE

J. J. J. J.

M.D.

23B. ADDRESS

4940 Eastern Ave

23C. DATE SIGNED

7-10-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

UNIVERSITY MEDICAL SCHOOL JUL 17 1950

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

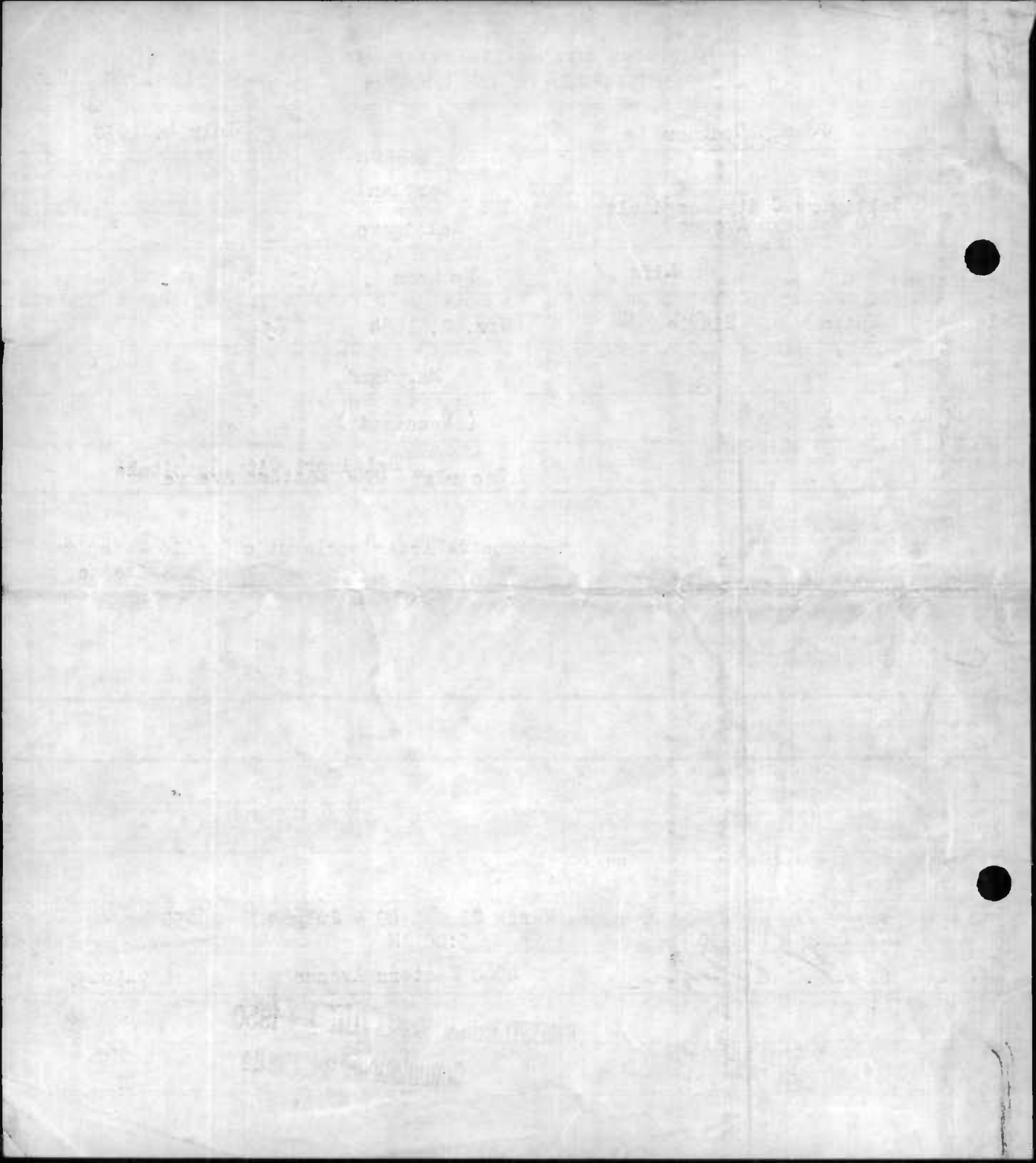
Commissioner of Health

ADDRESS

Information obtained from State Board of Health. 8/28/50.

BIRTH NO. 50 6301		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 6301 Registered No.	
1. NAME OF DECEASED (Type or Print) Joseph Lockner			2. DATE OF DEATH July 4, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-12		
c. Length of stay in Baltimore Life			D. STREET ADDRESS (If rural, give location) No Home B.C.H.		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Nov. 2, 1884	9. AGE (in years last birthday) 65	If Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME (Deceased)			12. CITIZEN OF WHAT COUNTRY?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Records* Baltimore City Hospitals 4940 Eastern Avenue			ADDRESS		
18. 443x1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Hypertensive Arteriosclerotic Cardio Vascular Disease DUE TO ANTECEDENT CAUSES (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 23, 1949, to July 4, 1950 that I last saw the deceased alive on July 4, 1950 and that death occurred at 5:00 AM, from the causes and on the date stated above.					
23A. SIGNATURE H. Rogers		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 7-10-50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		24E. DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1950		24F. REGISTRAR'S SIGNATURE Huntington Williams, M.D.	
24G. FUNERAL DIRECTOR Commissioner of Health		24H. ADDRESS		24I. DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1950	

MEDICAL CERTIFICATION





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 6302

1. NAME OF DECEASED (Type or Print) <b>WILLIAM MILTON GILL</b>		2. DATE OF DEATH <b>July 17, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>5217 Tramore Rd.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>5217 Tramore Rd.</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Mar. 18, 1872</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	9. AGE (In years last birthday) <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William M. Gill</b>		14. MOTHER'S MAIDEN NAME <b>Estelle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-10-3667</b>	
17. INFORMANT <b>Mrs. Anna Gill</b>		ADDRESS <b>5217 Tramore Rd.</b>	
18. <b>E900.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolus</b> DUE TO <b>Phlebotrombosis</b> DUE TO <b>Fracture, rt femur</b> DUE TO <b>6 wks.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>CERTIFICATION APPROVED BY</b> <b>R. B. Fisher</b> M. D. SELF OR ASSIST. MEDICAL EXAMINER <b>6 wks.</b>	
19A. DATE OF OPERATION <b>June 1, 1950</b>		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>accident</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>5217 Tramore Road</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>June, 1950 ?</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Fell down cellar steps</b>	
22. I hereby certify that I attended the deceased from <b>June 1950</b> to <b>July 17, 1950</b> , that I last saw the deceased alive on <b>July 17, 1950</b> , and that death occurred at <b>3:20 AM</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Charles J. Blazek</b> M. D.		23B. ADDRESS <b>2008 Ramblwood Rd.</b>	
23C. DATE SIGNED <b>7/17/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/20/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>July 17, 1950</b>		25. FUNERAL DIRECTOR <b>Wm. J. Schenker &amp; Sons</b> ADDRESS <b>Balto</b>	
REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>			



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6303

BIRTH NO. 50 6303

1. NAME OF DECEASED  
(Type or Print)

JOHN GRIFFIN

2. DATE  
OF  
DEATH

July 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

1800 W. North Ave.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE  
Md.C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)

1800 W. North Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
married

8. DATE OF BIRTH

Oct. 4, 1873

9. AGE (In year,  
last birthday)

76

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Glass Blower (rtd)

10B. KIND OF BUSINESS OR  
INDUSTRY

Glass Mfg

11. BIRTHPLACE (State or foreign country)

Canada

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

212-05-8223

17. INFORMANT

ADDRESS

Mrs. Lillian Griffin 1800 W. North Ave.

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Chronic Ischemic Myocarditis

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Excess Myocardial Hypertrophy  
Hypertensive Congestion

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1944, to July 17, 1950, that I last saw the  
deceased alive on July 17, 1950, and that death occurred at 2 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

M. O.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
Burial

24B. DATE

7/20/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 150

131a Md.

0011 100

0011 100

SEP 11 1964  
RECEIVED  
U.S. AIR FORCE  
OFFICE OF THE  
JOINT CHIEFS OF STAFF  
WASHINGTON, D.C.

260

BIRTH NO. 50 6304

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

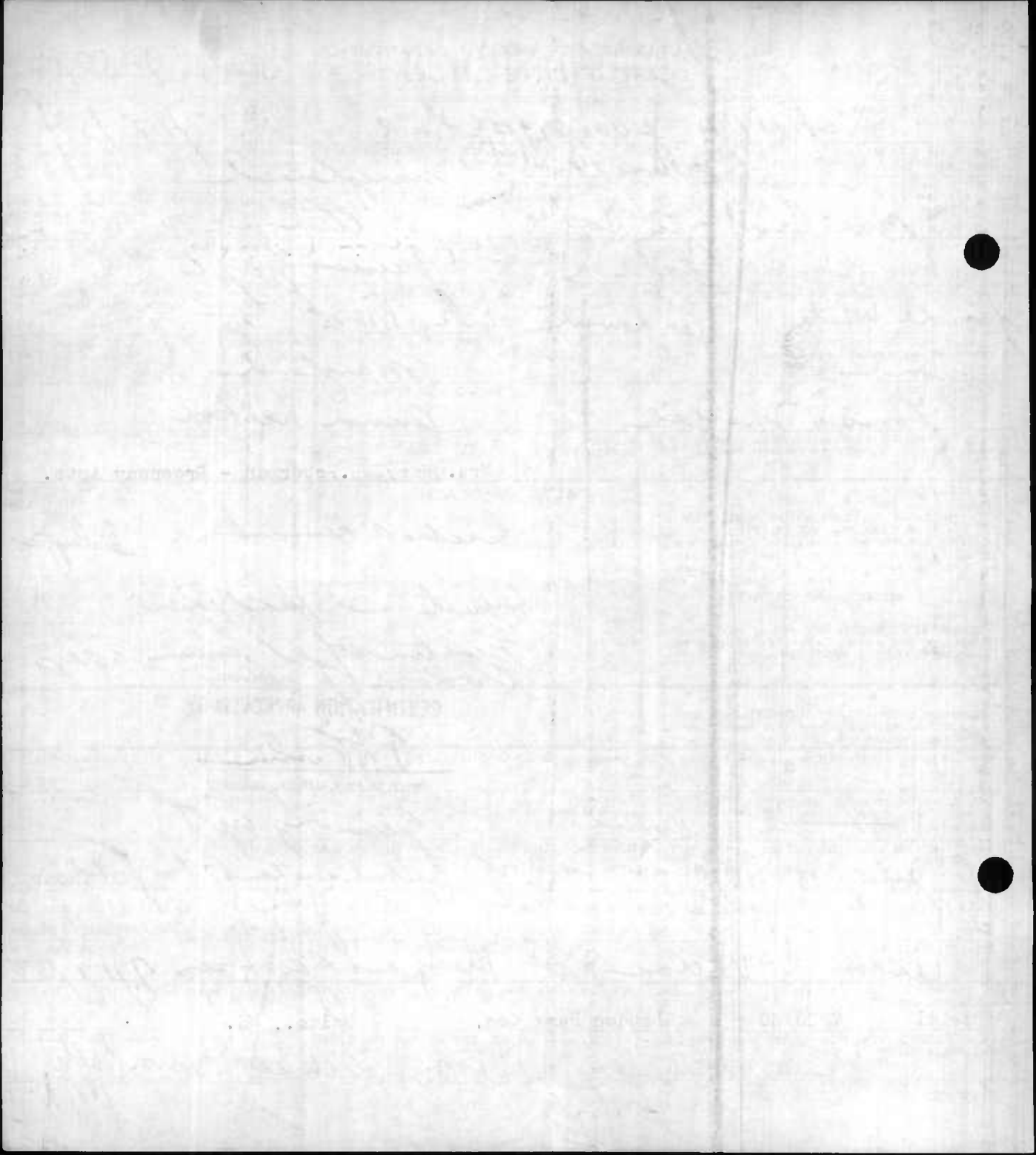
Registered No. 50 6304

1. NAME OF DECEASED (Type or Print) <b>ANNA - LOUISE ECKER.</b>		2. DATE OF DEATH <b>7/17/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland Gen. Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore - 12-02</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>344 Greenway Apts. # 8 Charles</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 1, 1875</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>75</b>
13. FATHER'S NAME <b>Louis G. Meyer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Anna Melker</b>	
17. INFORMANT		ADDRESS <b>Mrs. Harry E. Peterman - Greenway Apts.</b>	

18. <b>443 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Hypertension, Head Injury</b>		
		(C) <b>Fracture of left femur, Fracture of pelvis</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CERTIFICATION APPROVED BY <b>R. E. Fisher</b> M. D.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? <b>Greenway Apts.</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 13, 1950 9 P.M.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Cerebral accident, then fell to floor</b>	
22. I hereby certify that I attended the deceased from <b>July 14, 1950</b> , to <b>July 17, 1950</b> , that I last saw the deceased alive on <b>July 17, 1950</b> , and that death occurred at <b>1:15 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Anthony C. Verone M.D.</b>		23B. ADDRESS <b>Maryland Gen. Hosp.</b>		23C. DATE SIGNED <b>7/17/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>III 19 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams M.D.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Tinkner &amp; Sons</b>		ADDRESS <b>Balto. Md.</b>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6305**

*562*  
*50 6305*  
*Issued by M.E. McFadden*

1. NAME OF DECEASED (Type or Print) <b>MARY (MARYANNA) ZAMERSKI</b>		2. DATE OF DEATH <b>July 16, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>503 S. Bradford Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
6. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>503 S. Bradford Street</b>	
7. SEX <b>Female</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	10. DATE OF BIRTH <b>December 15, 1882</b>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Household</b>	12. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	13. BIRTHPLACE (State or foreign country) <b>Maryland</b>	14. CITIZEN OF WHAT COUNTRY? <b>USA</b>
15. FATHER'S NAME <b>Joseph Czosnowski</b>		16. MOTHER'S MAIDEN NAME <b>Teofila Trybulska</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>-----</b>	
19. INFORMANT <b>Mr. Anthony Zamerski</b>		ADDRESS <b>1801 Bank Street</b>	

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Degeneration</b> DUE TO ANTECEDENT CAUSES <b>arteriosclerotic - vascular disease</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) <b>-----</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b> <b>3 yrs.</b>
--	--	--

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>CERTIFICATION APPROVED BY</b> <i>B.S. Fisher</i> M.D. <b>CHIEF OR ASST. MEDICAL EXAMINER.</b>	
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19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION <b>-----</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-----</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-----</b>
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>-----</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>-----</b>

22. I hereby certify that I attended the deceased from **June 17, 1950** to **July 16, 1950**, that I last saw the deceased alive on **June 17, 1950**, and that death occurred at **8:30 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE <i>Dr. J. S. Fisher</i>	23B. ADDRESS <b>476 S. Patterson Park Ave.</b>	23C. DATE SIGNED <b>7/18/50</b>
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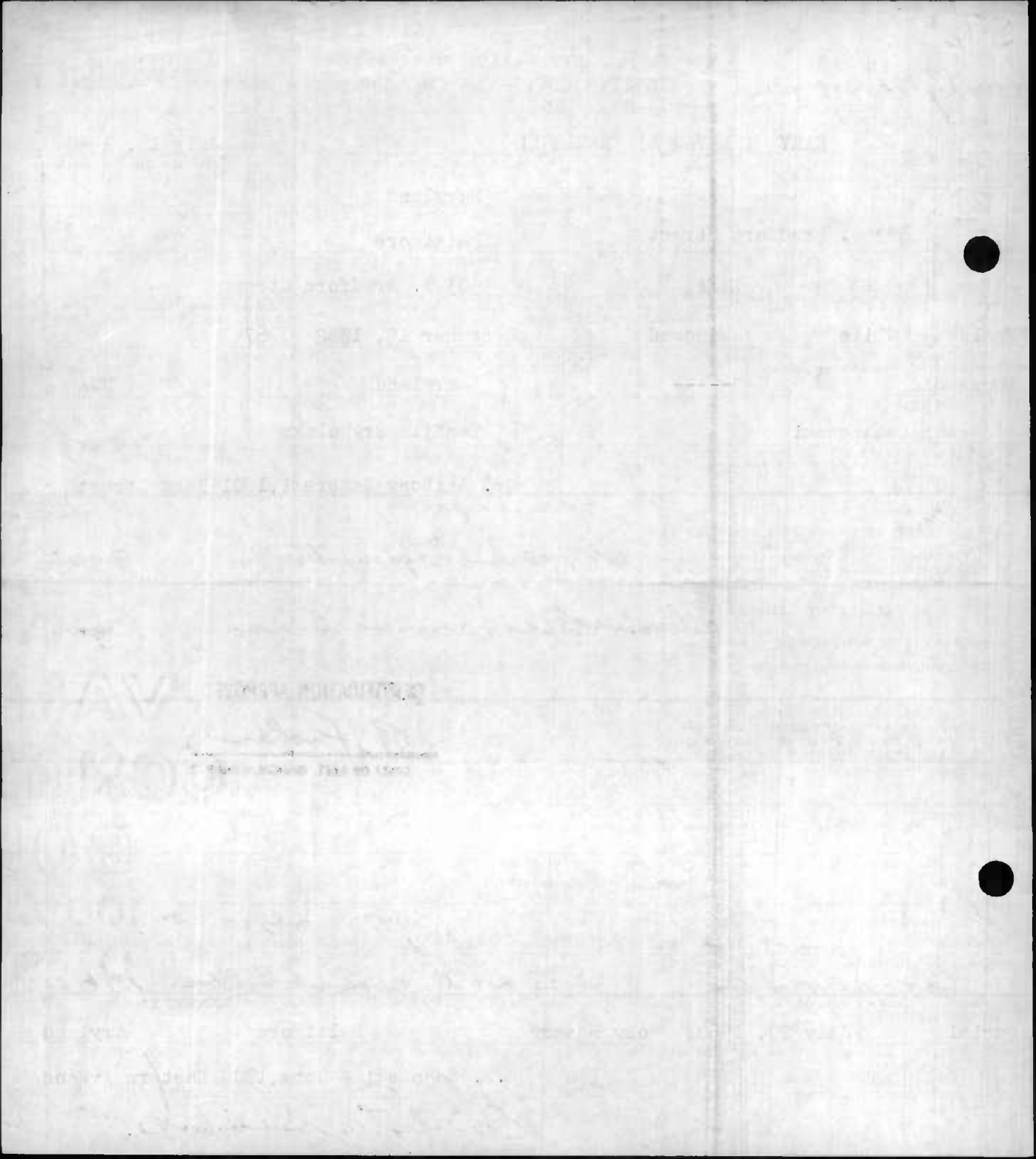
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 20, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>	24D. LOCATION (City and county) (State) <b>Baltimore Maryland</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>	REGISTRAR'S SIGNATURE <i>William Williams</i>	25. FUNERAL DIRECTOR ADDRESS <b>M.E. Sadowski &amp; Sons, 1808 Eastern Avenue</b>
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VS 150

*Charles W. Sadowski '93'*

MEDICAL CERTIFICATION



323

50 6306

BIRTH NO.

LIDSTON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 6306

1. NAME OF DECEASED (Type or Print)

MRS. MARY E. LIDSTON

2. DATE OF DEATH

JULY 17, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland (ST. JOSEPH'S HOSP)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MARYLAND B. COUNTY Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION

ST. JOSEPH'S HOSPITAL

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

BALTIMORE Dundell

7. STREET ADDRESS (If rural, give location)

24 FLAGSHIP RD 5300

8. LENGTH OF STAY IN BALTIMORE

68 Yrs. Mos. Days

9. SEX

F

10. COLOR OR RACE

W

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED

12. DATE OF BIRTH

12/14/81

13. AGE (In years last birthday)

68

14. If Under 1 Year Months: Days

15. If Under 24 Hours Hours: Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

17. KIND OF BUSINESS OR INDUSTRY

18. BIRTHPLACE (State or foreign country)

B. OCEANA, MD.

19. CITIZEN OF WHAT COUNTRY?

U.S.A.

20. FATHER'S NAME

Adolph Stiegler

21. MOTHER'S MAIDEN NAME

Catherine Thomas

22. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

NO

23. SOCIAL SECURITY NO.

24. INFORMANT

Thomas Clark

25. ADDRESS

1907 Tyler Rd.

26. CAUSE OF DEATH

(A) CEREBRAL HEMORRHAGE

DUE TO

(B) HYPERTENSIVE C.V. DISEASE

DUE TO

(C)

27. INTERVAL BETWEEN ONSET AND DEATH

2 DAYS

28. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

II

29. ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

30. DATE OF OPERATION

0

31. MAJOR FINDINGS OF OPERATION

32. AUTOPSY?

YES ☐ NO ☒

33. 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

34. 22. TIME (Month) (Day) (Year) (Hour) INJURY

23. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

24. 21F. HOW DID INJURY OCCUR?

35. 22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

25. 23A. SIGNATURE

26. 23B. ADDRESS

27. 23C. DATE SIGNED

28. 24A. BURIAL, CREMATION, REMOVAL (Specify)

29. 24B. DATE

30. 24C. NAME OF CEMETERY OR CREMATORY

31. 24D. LOCATION (City, town, or county) (State)

32. DATE RECEIVED BY LOCAL REGISTRAR

33. REGISTRAR'S SIGNATURE

34. 25. FUNERAL DIRECTOR

35. ADDRESS

36. VS 150

93D

37. MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1891

1891

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6307**

BIRTH NO. **50 6307**

1. NAME OF DECEASED  
(Type or Print)

*Lloyd M. Pearson, Jr.*

2. DATE  
OF DEATH

*July 18, 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland

*Red. H-H-2*

B. FULL NAME OF HOSPITAL OR INSTITUTION

**JOHNS HOPKINS HOSPITAL**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*51 Maryland*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Child*

8. DATE OF BIRTH

*2-12-145*

9. AGE (In years last birthday)

*5*

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Richmond Va.*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Lloyd M. Pearson*

14. MOTHER'S MAIDEN NAME

*Larry Hardy*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

**JOHNS HOPKINS HOSPITAL**

ADDRESS

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Cardiac Failure*  
DUE TO *Chronic Nephritis & Nephrosis*

INTERVAL BETWEEN ONSET AND DEATH

*Immediate*

*4 years*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I hereby certify that I attended the deceased from *7-18-* 19 *50* to *7-18-* 19 *50* that I last saw the deceased alive on *7-19-* 19 *50* and that death occurred at *P. m.*, from the causes and on the date stated above.

23A. SIGNATURE

*Carl Swan Shultz*

M. D.

23B. ADDRESS

**JOHNS HOPKINS HOSPITAL**

23C. DATE SIGNED

*7-18-50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

*Burial*

24B. DATE

*7-21-50*

24C. NAME OF CEMETERY OR CREMATORY

*Forest Lawn Cem*

24D. LOCATION (City, town, or county)

*Richmond Va*

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Wilmington Williams, M.D.*

25. FUNERAL DIRECTOR

*John C. Miller Inc - 2435 E. Olney St*

ADDRESS

**JUL 19 1950**

VS 150

*131B*

MEDICAL CERTIFICATION

Immediate

4-20-82

Complete Failure  
+ Chronic Nephritis  
Nephritis

2-18-80



# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 6308  
Registered No.

160  
50 6308  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) **CLYDE T. FIFER** 2. DATE OF DEATH **July 16, 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland  
B. FULL NAME OF (If not in hospital or institution, give street address or location) **Mercy Hospital**  
C. Length of stay in Baltimore  
Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Washington D.C.** B. COUNTY **V-47**  
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
D. STREET ADDRESS (If rural, give location)  
5. SEX **Male** 6. COLOR OR RACE **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Married**  
8. DATE OF BIRTH **Feb. 2-1913** 9. AGE (In years last birthday) **36 37** 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Painter** 10. B. KIND OF BUSINESS OR INDUSTRY **New York Decorators Work D.C.**  
11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?  
13. FATHER'S NAME **Samuel J. Fifer** 14. MOTHER'S MAIDEN NAME **Sallie Cash**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes World War II** 16. SOCIAL SECURITY NO. **223-07-5572** 17. INFORMANT **Geraldine W. Fifer 101 Ivy Ave.** ADDRESS

18. **E929.8** CAUSE OF DEATH **Highland Springs Va** INTERVAL BETWEEN ONSET AND DEATH  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) **Drowning (found drowned)** DUE TO  
ANTECEDENT CAUSES (B) **Acute alcoholism** DUE TO  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C)  
II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☒  
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Harbor** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Pier #4, Pratt St.**  
21D. TIME (Month) (Day) (Year) (Hour) **July 16, 1950** 21E. INJURY OCCURRED **abt. 11:15 P.M.** WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **Apparently fell into harbor, while washing his clothes, while drunk**

22. I certify that I took charge of the remains described above, held an **Inspection & Inq.** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE **Stanley H. Dunbar** M.D. 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **July 17, 1950**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **7-20-50** 24C. NAME OF CEMETERY OR CREMATORY **Riverside Cem** 24D. LOCATION (City, town, or county) (State) **Richmond Va**  
DATE RECEIVED BY LOCAL REGISTRAR **JUL 19 1950** REGISTRAR'S SIGNATURE **Washington Williams, M.D.** 25. FUNERAL DIRECTOR **Ray C. Milby Inc. 2435 E. Olive St** ADDRESS

CERTIFICATE OF DEATH

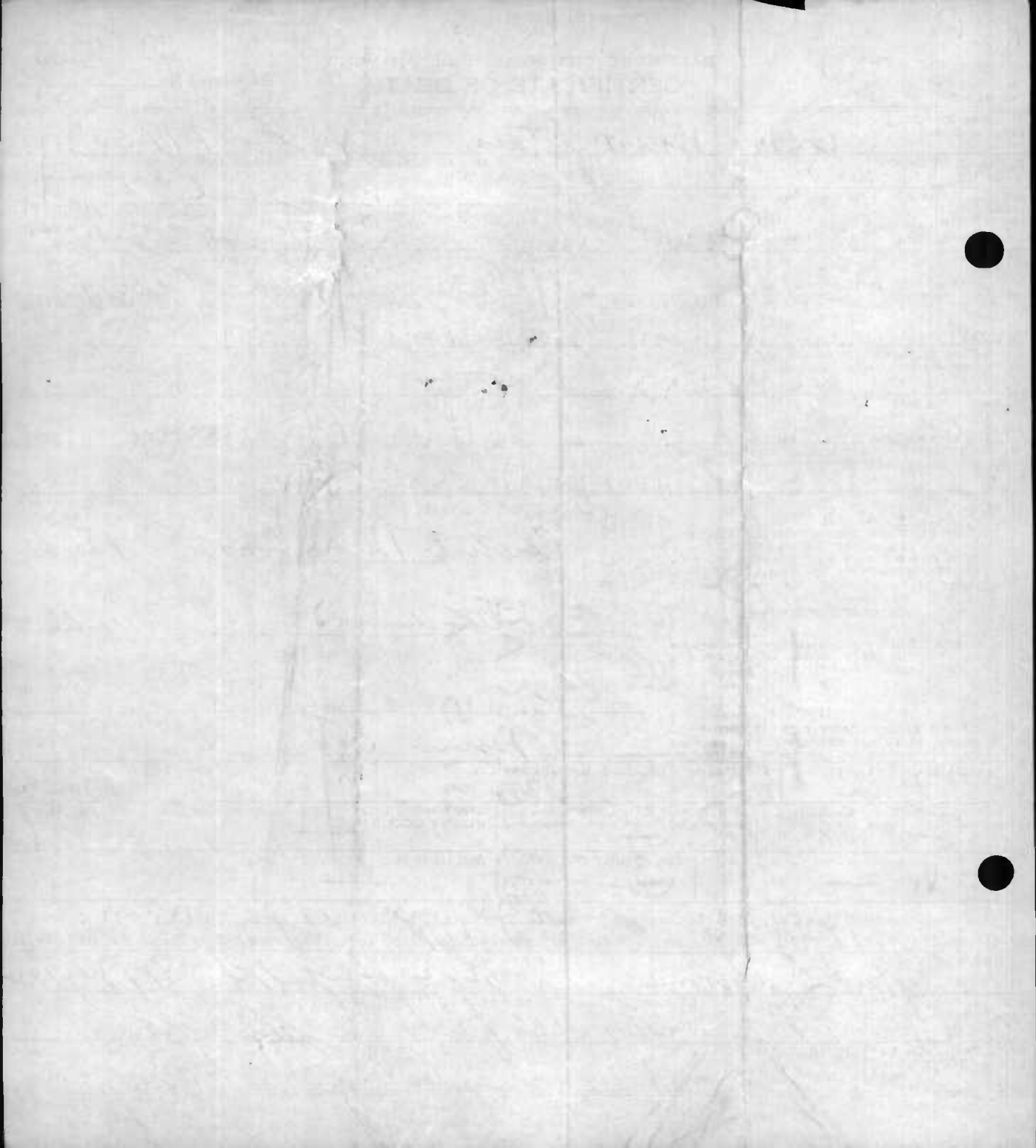
DECEASED

DATE OF DEATH

PLACE OF DEATH

SIGNATURE OF DECEASED





-450  
50 6310

WHALEN  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6310  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Gertrude Whalen</i>		2. DATE OF DEATH <i>7/18/50</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Md General Hosp.</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore Parkville</i>			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>8005 Bonair Rd 5300</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb. 18-1891</i>	9. AGE (In years last birthday) <i>59</i>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balt Md</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Cloma Parsons</i>		14. MOTHER'S MAIDEN NAME <i>Henrietta</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr James S. Whalen</i> ADDRESS <i>8005 Bonair</i>	

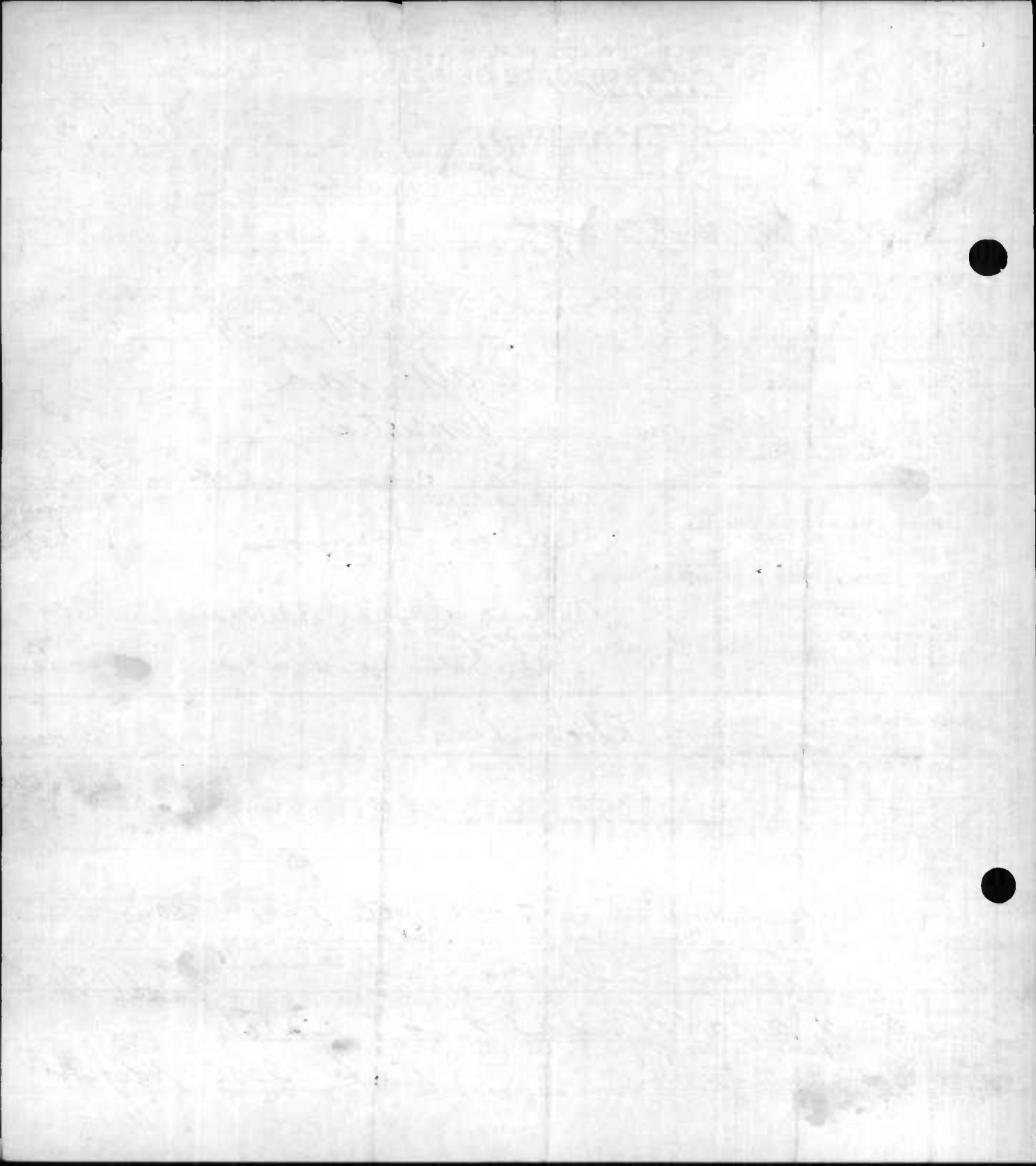
18. <i>760 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Cerebral thrombosis</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO <i>P yr</i> (C) <i>Diabetes mellitus</i> <i>P years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Rt Hemiplegia</i>		18 days	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *7-1*, 19*50* to *7-18*, 19*50*, that I last saw the deceased alive on *7/18*, 19*50*, and that death occurred at *235 P.* m., from the causes and on the date stated above.

23A. SIGNATURE *Margaret Louisa Cadell* M. D. 23B. ADDRESS *Maryland General Hosp.* 23C. DATE SIGNED *7/18/50*

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/21/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Morland Park</i>		24D. LOCATION (City, town, or county) (State) <i>Balt Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>III 19 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>L. J. Luck</i>		ADDRESS <i>5305 Harford</i>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

BIRTH NO. 50 6311

1. NAME OF DECEASED  
(Type or Print)

*Casimir Baron*

2. DATE OF DEATH

*July 17, 1950*

3. PLACE OF DEATH:

a. Baltimore City, Maryland

*Med. Oct 6*

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

before admission)

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

*JOHNS HOPKINS HOSPITAL*

c. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

d. STREET ADDRESS (If rural, give location)

*830 S. Bond St*

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*Male*

6. COLOR OR RACE

*White*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

*Single*

8. DATE OF BIRTH

*1-2-92*

9. AGE (in years last birthday)

*58*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

*?*

11. BIRTHPLACE (State or foreign country)

*?*

12. CITIZEN OF WHAT COUNTRY?

*?*

13. FATHER'S NAME

*?*

14. MOTHER'S MAIDEN NAME

*?*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

*?*

17. INFORMATION ADDRESS

*JOHNS HOPKINS HOSPITAL*

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) DUE TO

*Myocardial Infarction*

(B) DUE TO

*Atherosclerotic Coronary*

(C)

*Thrombosis*

INTERVAL BETWEEN ONSET AND DEATH

*5 wks*

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

*Generalized Atherosclerosis*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) INJURY

21e. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *6-16-1950* to *7-17-1950* that I last saw the deceased alive on *7-17-1950* and that death occurred at *3:05 p.m.*, from the causes and on the date stated above.

23a. SIGNATURE

M. D.

23b. ADDRESS

*JOHNS HOPKINS HOSPITAL*

23c. DATE SIGNED

*7-18-50*

24a. BURIAL, CREMATION, REMOVAL (Specify)

*BURIAL*

24b. DATE

*JULY 19 1950*

24c. NAME OF CEMETERY OR CREMATORY

*MOUNT CARMEL CEM*

24d. LOCATION (City, town, or county)

*O'DONELL ST.*

(State)

*MD.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

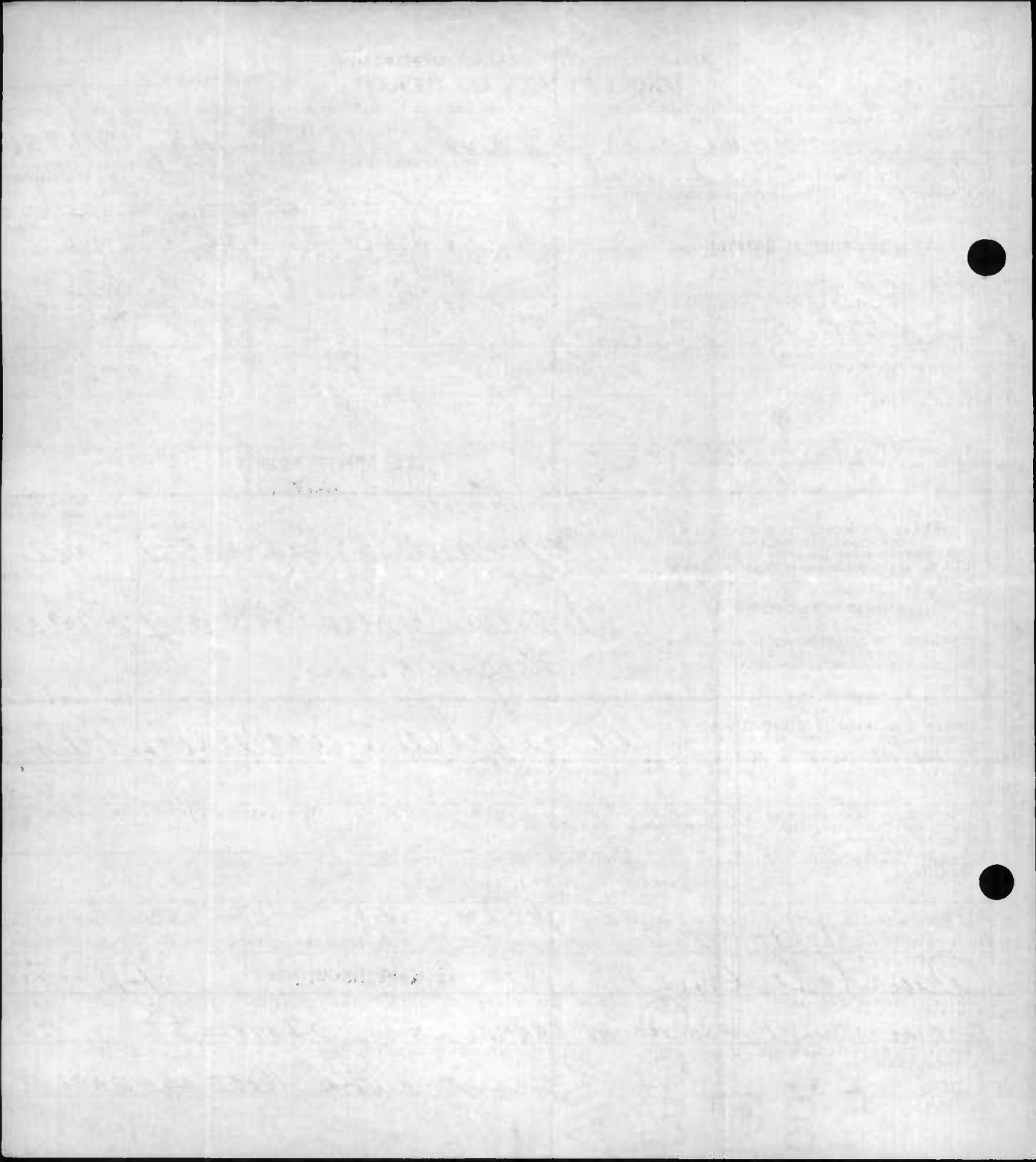
*19 1950*  
VS 150

*William Williams, M.D.*

*Duffel Bldg 1800 E LOMBARD ST.*

*94a*

MEDICAL CERTIFICATION



Lc  
139247

B-635  
50 6312

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6312

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rachel Burton		2. DATE OF DEATH July 17, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore 2 Yrs. Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1525 E. Lombard St.	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 14, 18 82
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9. AGE (In years last birthday) 67	
10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Phillips		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Records Baltimore City Hospitals		ADDRESS 4940 Eastern Ave.	

18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from June 27, 1950, to July 17, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 6:00 PM, from the causes and on the date stated above.				
23A. SIGNATURE O. J. Rogers		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED 7-18-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 7-22-50	24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	24D. LOCATION (City, town, or county) (State) Brooklyn A.D. Co. Va
DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1950	REGISTRAR'S SIGNATURE Christington Williams	25. FUNERAL DIRECTOR Elroy O. Gibson 1000 Brantley Ave	

circ. 1000 147 000

H-252  
50 6313

50 6313

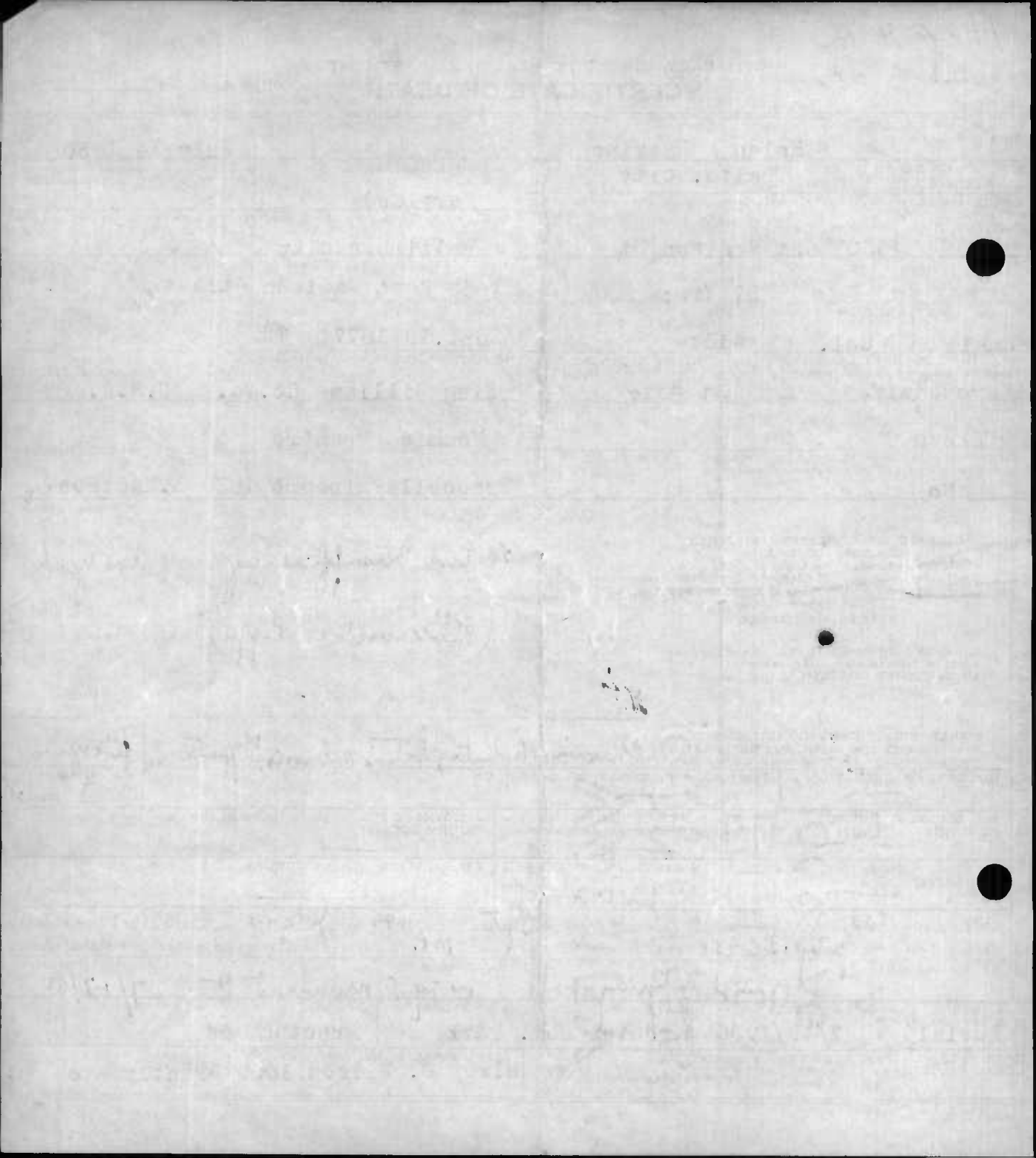
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Helen Haskins		July 14 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION I630 East Madison St		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore City 7-05			
c. Length of stay in Baltimore 57 Yrs.		D. STREET ADDRESS (If rural, give location) I630 East Madison Street			
5. SEX Female	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept. 19 1877	9. AGE (In years last birthday) 72	10. Under 1 Year Months: Days 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) King Williams Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mommie Uphire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Preecella Lipcomb I630 E. Madison St.	
18. 410X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Mitral Insufficiency (Rheumatic type) DUE TO INTERVAL BETWEEN ONSET AND DEATH one year		(A)			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)		DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Nephritis, Arterio Sclerosis, Hypertension (C)					
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> m. WORK AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept 1949, to July 14, 1950, that I last saw the deceased alive on July 13, 1950, and that death occurred at 10 P. m., from the causes and on the date stated above.					
23A. SIGNATURE Ralph J. Young		23B. ADDRESS 1424 E. Monument St. M. D.		23C. DATE SIGNED 7/17/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/19/1950		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park	
24D. LOCATION (City, town, or county) Arbutus Md		24E. FUNERAL DIRECTOR Elroy O. Wilson		24F. ADDRESS 1000 Brantly Ave	

JUL 19 1950  
VS 450

131a





2-250  
50 6314BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6314  
Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		James Dixon		2/15/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
B. FULL NAME OF (If not in hospital or institution, give street address or location)		A. STATE			
HOSPITAL OR INSTITUTE		B. COUNTY			
Provident Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
D. STREET ADDRESS (If rural, give location)		14-03			
c. Length of stay in Baltimore		1305 N. Front St			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
M	C	Widowed		67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
LABORER		000 JOBS	Sumit Point, W. Va.,		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James H. Dixon		Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(If yes, give war or dates of service)				Bertina Bond 1547 Woodyear St	

18. 442X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
(A) Hypertensive cardiorenal disease		
ANTECEDENT CAUSES		
(B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
(C) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED
P. P. Tschirner M.D.		2/14/50
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY
Burial	7-19-50	Mt. Auburn
24D. LOCATION (City, town, or county)		(State)
Baltimore 30, Md		

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JUL 19 1950	Wm. A. Jackson, M.D.	Wm. A. JACKSON	916 PENNA. AVE

RECORDS OF THE  
CENTRAL BANK OF INDIA



A-235  
REA-136246 50 6315BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6315  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Lee Austin</b>			2. DATE OF DEATH <b>July 13, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>4-02</b>		
c. Length of stay in Baltimore <b>30 yrs.</b> Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>645 W. Mulberry Street (1)</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>June 17, 1889</b>	9. AGE (in years last birthday) <b>61</b>	If Under 1 Year Months: _____ Days: _____ If Under 24 Hours Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None LABORER UPA JOBS</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Lisbon Austin</b>		14. MOTHER'S MAIDEN NAME <b>Jane Cable</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Avenue</b>	

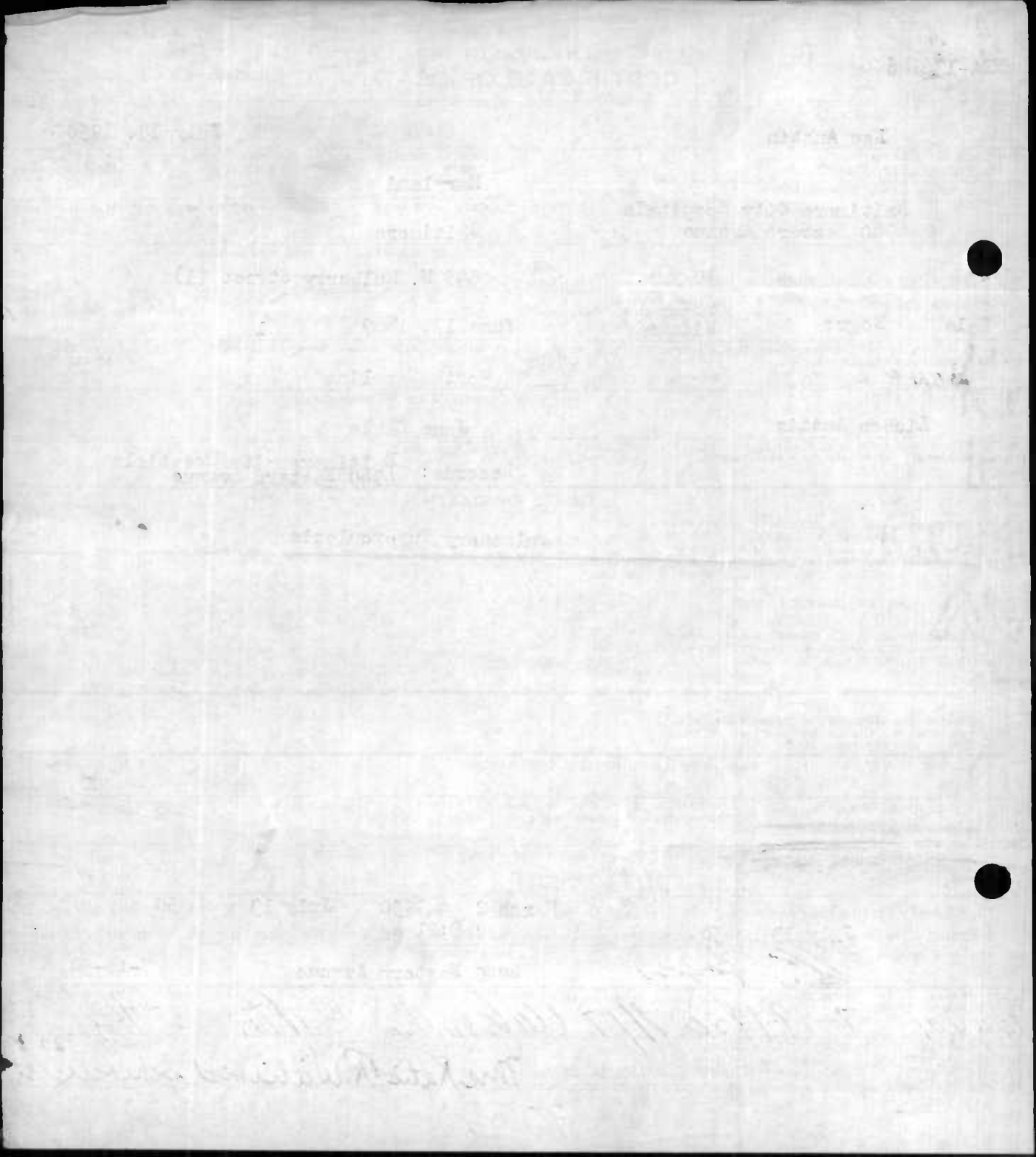
18. <b>002X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b> (A) _____ DUE TO _____	CAUSE OF DEATH <b>Pulmonary Tuberculosis</b> (B) _____ DUE TO _____ (C) _____	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>March 2</b> , 19 <b>50</b> , to <b>July 13</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 13</b> , 19 <b>50</b> , and that death occurred at <b>8:01 A.</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <b>W. Rogers</b> M. O.	23B. ADDRESS <b>4940 Eastern Avenue</b>	23C. DATE SIGNED <b>7-18-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-19-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>W. T. Calver Cem. Balto.</b>	24D. LOCATION (City, town, or county) (State) <b>MD</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Mrs. Kate R. Williams</b>	ADDRESS <b>322 S. Schroeder St.</b>

97099 1 1

13B



8-524  
50 6316

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6316

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HALLIE ENGLISH</b>		2. DATE OF DEATH <b>7-18-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>629 West Saratoga Street</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>B</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 30, 1912</b>	9. AGE (In years, last birthday) <b>38</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sealer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Construction Worker</b>		11. BIRTHPLACE (State or foreign country) <b>Sumter, S.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Solomon. English.</b>		14. MOTHER'S MAIDEN NAME <b>Lida Bennett.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Fannie English, 629 W. Saratoga St.</b>	
18. <b>332X I</b>		CAUSE OF DEATH			

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Massive infarct of brain**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Cause not known**

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <b>7</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 6, 1950</b> to <b>July 18, 1950</b> that I last saw the deceased alive on <b>July 18, 1950</b> , and that death occurred at <b>3:15 Am.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>E. D. [Signature]</b>		23B. ADDRESS <b>University Hosp.</b>		23C. DATE SIGNED <b>7-18-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-22-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>W. H. Williams Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>		ADDRESS <b>3221 [Address]</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>III 191950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams</b>			

970243 15

83B

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF HEALTH  
CENTRAL RECORDS DIVISION

RECORD OF DEATH

1910

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CITY AND COUNTY

STATE

AGE

SEX

OCCUPATION

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

CITY AND COUNTY

STATE

AGE

SEX

OCCUPATION

CAUSE OF DEATH



J-626  
50 6317

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6317

BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <b>Sophia M. Trager</b>		
2. DATE OF DEATH <b>July 17/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>16 S.Conkling St</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>--</b>		
C. Length of stay in Baltimore <b>life</b> Yrs. Mos. Days		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>
13. FATHER'S NAME <b>Frederick Krimmelbein</b>		14. MOTHER'S MAIDEN NAME <b>Fredia Lorenz</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>---</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>----</b>
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>16 S.Conkling St</b> B. COUNTY		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Md. 26-05</b>
D. STREET ADDRESS (If rural, give location) <b>16 S.Conkling St.</b>		8. DATE OF BIRTH <b>Oct. 7, 1893</b>
9. AGE (in years, last birthday) <b>56</b>		If Under 1 Year Months: Days Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?
17. INFORMANT ADDRESS <b>Mr. Harry A. Trager, 16 S.Conkling St.</b>		

18. <b>170x I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma of Ovaries</b> DUE TO <b>Primary Carcinoma of Breast</b> DUE TO <b>(C) ...</b>		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION <b>7-17-50</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>7-17-50</b> , 19 <b>50</b> , to <b>7-17-50</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-17-50</b> , 19 <b>50</b> , and that death occurred at <b>8 a. m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>John Constantine</b>	23B. ADDRESS <b>234 S. Conkling St.</b> M. D.	23C. DATE SIGNED <b>7-19-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 21/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cem.</b>
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Philip H. Hering, 2024 Orleans St.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		
REGISTRAR'S SIGNATURE <b>William M. Williams</b>		

MEDICAL CERTIFICATION

50

VALLEY

EXPRESS

BOND

ODX/HAG

1/3/5

G-610  
50 6318BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6318  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HERBERT Julius Grieb

2. DATE  
OF  
DEATH

July 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

4205 Kolb Ave.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4205 Kolb Ave.

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

June 9, 1900

9. AGE (In years  
last birthday)

50

10 Under 1 Year  
Months; Days11 Under 24 Hours  
Hours; Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Certif. Pub. Accountant

10B. KIND OF BUSINESS OR  
INDUSTRY

Accounting

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Christian Grieb

14. MOTHER'S MAIDEN NAME

Adele Lutjerath

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
213-09-5781

17. INFORMANT

ADDRESS

Mrs. Harry A. Klein - 15 E. Maple Ave.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

Coronary Thrombosis

5 minutes.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B)

Cardio-Vascular Hypertensive Disease

10 years.

DUE TO

(C)

Arteriosclerosis

10 years.

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 5, 1948, to July 18, 1950, that I last saw the  
deceased alive on July 6, 1950, and that death occurred at 7:35 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Michael J. Dausch

M. D.

23B. ADDRESS

4636 Belair Road

23C. DATE SIGNED

7/18/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/21/50

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cem

24D. LOCATION (City, town, or county)

Balto. Co., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. J. Tiekner &amp; Sons - Balto.

ADDRESS

Md.

VS 150

00081

93D

STATE OF NEW YORK  
CERTIFICATE OF DEATH

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

NAME OF PHYSICIAN

SIGNATURE OF PHYSICIAN

DATE

TIME

PLACE OF BIRTH

STATE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

NAME OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

NAME OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

NAME OF BIRTH

DATE OF BIRTH

E-50 152  
6319BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6319

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>LENA EVANS</b>		2. DATE OF DEATH <b>July 18, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Wyman Park Drive &amp; 31st St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 16-01</b>	
c. Length of stay in Baltimore <b>?</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1114 N. Eden Street</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid.</b>	8. DATE OF BIRTH <b>3/27/16</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>34</b>
13. FATHER'S NAME <b>Robert Stellings</b>		11. BIRTHPLACE (State or foreign country) <b>NC</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>?</b> (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. SOCIAL SECURITY NO. <b>?</b>		14. MOTHER'S MAIDEN NAME <b>Ella Mc Millen</b>	
17. INFORMANT <b>Records- US Marine Hospital, Balto, Md.</b>		ADDRESS	

18. **331X** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Hemorrhage, cerebral massive, due to hypertension**  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.  
DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **?** 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?22. I hereby certify that I attended the deceased from **July 18, 1950** to **July 18, 1950**, that I last saw the deceased alive on **July 18, 1950**, and that death occurred at **3:43A** m., from the causes and on the date stated above.23A. SIGNATURE **D.W. Patrick, Medical Director** M. D. 23B. ADDRESS **US Marine Hospital, Balto, Md.** 23C. DATE SIGNED **7/19/50**24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **July 19/50** 24C. NAME OF CEMETERY OR CREMATORY **Mt Calvary Cem** 24D. LOCATION (City, town, or county) (State) **G. G. County Md**DATE RECEIVED BY LOCAL REGISTRAR **JUL 19 1950** REGISTRAR'S SIGNATURE **Huntington Williams, M.D.** 25. FUNERAL DIRECTOR **Mrs. Robert G. Edwards & Daugherty** ADDRESS **1129 N. Caroline St. 83a**

UNITED STATES DEPARTMENT OF THE ARMY  
CENTRAL OFFICE OF THE ARMY

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P-235  
50 6320

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6320  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SARAH E. POSTON</b>		2. DATE OF DEATH <b>July 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Good SAMARITAN HOME</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-03</b>			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>3224 Clifmont Avenue</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>		8. DATE OF BIRTH <b>Oct. 9, 1893</b>	9. AGE (In years last birthday) <b>56</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Bellvue, Pennsylvania</b>	
13. FATHER'S NAME <b>John McClure</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Sarah Schmier, 2726 Prospect St.</b>	
10. MOTHER'S MAIDEN NAME <b>Ida F. Minor</b>					

18. <b>171X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CANCER OF THE Cervix Discovered</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 1, 1950</b> , to <b>July 18, 1950</b> , that I last saw the deceased alive on <b>July 14, 1950</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Melvin M. Borden</b>		23B. ADDRESS <b>2030 W. Fayette St</b>		23C. DATE SIGNED <b>July 18, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. Cook, Inc.</b>		25. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul Street</b>	

48a

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Mayor

Signature of Governor

N-250  
50 6321

50 6321

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. _____	
1. NAME OF DECEASED (Type or Print) <b>SIMON NESIN</b>	
2. DATE OF DEATH <b>JULY 19, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH <b>Aug. 23, 1885</b>	
9. AGE (In years last birthday) <b>64</b>	
10. UNDER 1 Year Months: Days <b>II 26</b>	
11. UNDER 24 Hours Hours: Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Gibbs Can Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Hungary</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Voliko Nesin</b>	
14. MOTHER'S MAIDEN NAME <b>Katica Szalagji</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. _____	
17. INFORMANT ADDRESS <b>Anna M. Nesin 346 E. 28th. St.</b>	

18. **4200**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **ARTERIOSCLEROTIC HEART DISEASE**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) \_\_\_\_\_  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) \_\_\_\_\_

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED M. _____ WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 19, 1950</b> to <b>July 19, 1950</b> that I last saw the deceased alive on <b>July 19, 1950</b> , and that death occurred at <b>12:30 Am.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Edmund B. Middleton</b>		23B. ADDRESS <b>University Hospital</b>		23C. DATE SIGNED <b>July 19, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-22-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 19 1950</b>		24F. REGISTRAR'S SIGNATURE <b>John Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Wm. Cook Inc.</b>		25A. ADDRESS <b>1217 St. Paul St.</b>		25B. SIGNATURE <b>Raymond F. Meyer</b>	

54442

937

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

OFFICE OF THE CHIEF OF BUREAU

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WASHINGTON, D. C.

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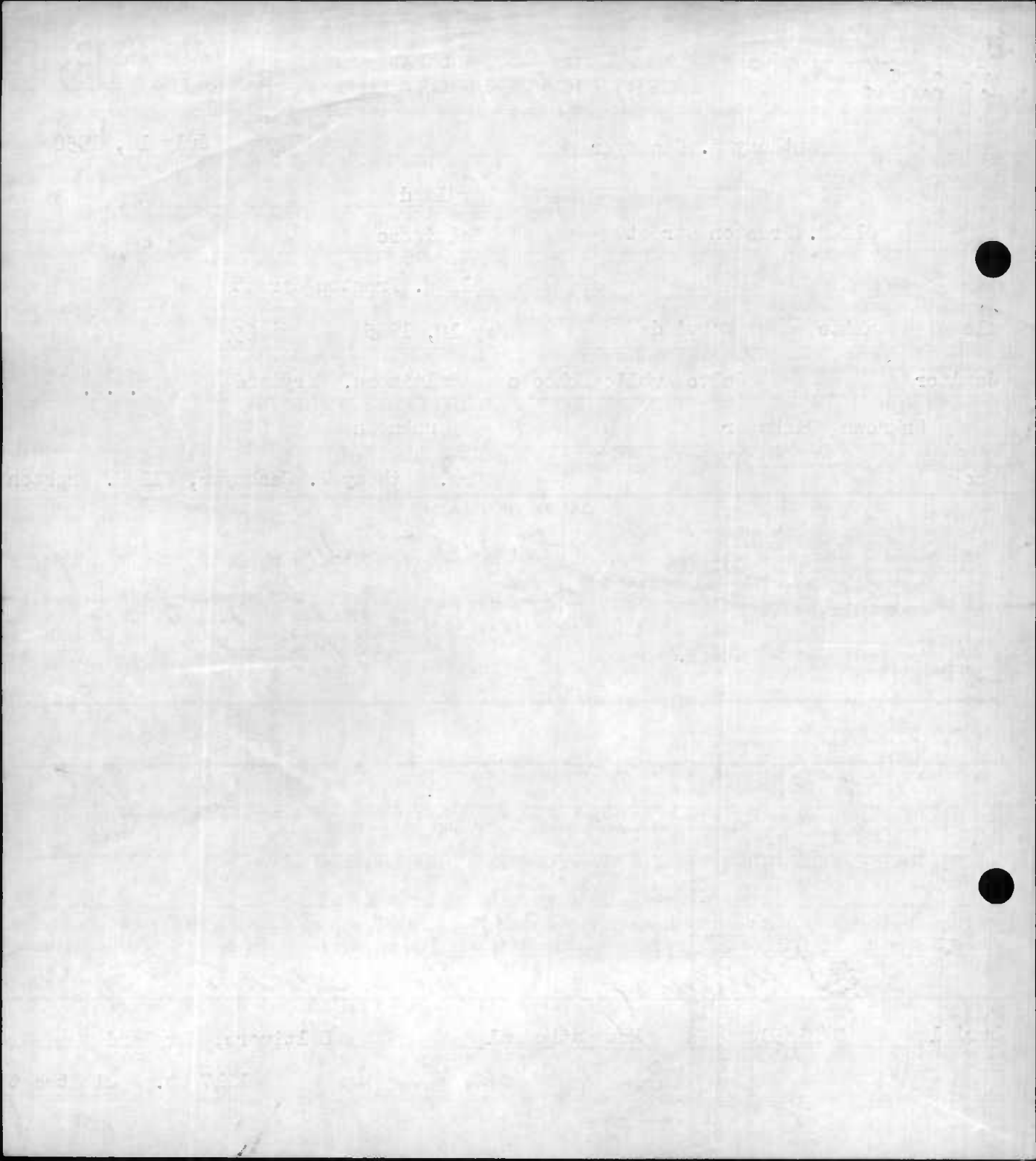
WASHINGTON, D. C.

WASHINGTON, D. C.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6322  
Registered No. \_\_\_\_\_

BIRTH NO. <u>C-2588</u> <u>76322</u>		2. DATE OF DEATH <u>July 18, 1950</u>	
1. NAME OF DECEASED (Type or Print) <u>Anthony J. Cashmyer</u>			
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>812 E. Preston Street</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>9-09</u>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>812 E. Preston Street</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>May 10, 1885</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Public Schools</u>	9. AGE (in years last birthday) <u>65</u> If Under 1 Year: Months: _____ Days: _____ If Under 24 Hours: Hours: _____ Min: _____
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Cashmyer</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Mrs. Anthony J. Cashmyer</u>		ADDRESS <u>812 E. Preston</u>	
18. <u>442X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Thrombosis</u> DUE TO _____  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Arteriosclerotic Cardiac Disorder</u> DUE TO _____ <u>Renal Disease</u> DUE TO _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u>	
19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____ m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <u>7/14</u> , 19 <u>50</u> , to <u>7/19</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7/18</u> , 19 <u>50</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23A. SIGNATURE <u>John S. Blum</u> M. D.		23B. ADDRESS <u>1115 N. Calver St.</u>	
23C. DATE SIGNED <u>7/19/50</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24B. DATE <u>7/21/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>Jul 19 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. Book, Inc.</u>	25. FUNERAL DIRECTOR ADDRESS <u>1217 St. Paul Street</u>	





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50 6323

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6323

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Virginia Almond</i>		2. DATE OF DEATH <i>7/18/50</i>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <i>Baltimore Md.</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>25-32</i>	
b. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR W. S. CHERRY HILL <i>South of WATERVIEW AVE.</i> (Location) INSTITUTION <i>2930 Cherry Hill Rd.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>7 Mos. 1 Day</i>		d. STREET ADDRESS (If rural, give location) <i>2930 Cherry Hill Rd.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 11, 1906</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>44</i>
11. BIRTHPLACE (State or foreign country) <i>Greenbrier Co. W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Henry B. Jones</i>		14. MOTHER'S MAIDEN NAME <i>Susan Thompson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Joshua Jones, Amherst, Va.</i>		ADDRESS	

18. *581.0* I  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(A) *Asphyxia*  
DUE TO *asphyxia*  
(B) *Tracheitis*  
DUE TO *Tracheitis*

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/17</i> , 19 <i>50</i> , to <i>7/18</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7/18</i> , 19 <i>50</i> , and that death occurred at <i>6 P. m.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Samuel Rubin</i>		23B. ADDRESS <i>203 Batopasco Ave</i>		23C. DATE SIGNED <i>7/19/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/20/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Family Plot, Amherst</i>	
24D. LOCATION (City, town, or county) (State) <i>Amherst Co. Va.</i>		25. FUNERAL DIRECTOR <i>Janus H. Lyons</i>		ADDRESS <i>4001 Ritchie Hwy</i>	

MEDICAL CERTIFICATION

UL 191950  
VS 150

124B

Prof 1866



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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6325  
Registered No.

140  
0 6325  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CENEUIEVE IRENE GIBULA</b>		2. DATE OF DEATH <b>7/18/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <b>ST. JOSEPH'S HOSP DEPT</b>		C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <b>BALTO</b>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>85 S. Miller</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Jan. 1908 42</b>
10A. USUAL OCCUPATION (Give kind of work on during most of working life, even if retired) <b>House Work at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Poland.</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>J. Glenn Bicki</b>		14. MOTHER'S MAIDEN NAME <b>Gank.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>John Gibula</b> ADDRESS <b>815 S. Milton</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral hemorrhage</b> DUE TO <b>hypertensive cardio-vascular disease</b>	CAUSE OF DEATH (A) <b>Cerebral hemorrhage</b> (B) <b>hypertensive cardio-vascular disease</b> (C)	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/18/50</b> , to <b>7/18/50</b> , that I last saw the deceased alive on <b>7/18/50</b> , and that death occurred at <b>7:30</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Moddens Sawinski</b> M. D.		23B. ADDRESS <b>St. Joseph's Hosp.</b>		23C. DATE SIGNED <b>7/18/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 23/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>		24E. FUNERAL DIRECTOR <b>Fred W. Ozyanski</b>		24F. ADDRESS <b>1936 Eastern Ave</b>	

DATE RECEIVED BY LOCAL REGISTRAR  
**JUL 20 1950**

REGISTRAR'S SIGNATURE  
**Wilmington Williams, MD**

MEDICAL CERTIFICATION





351

6326

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6326

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WILSON H STEMBLER

2. DATE  
OF  
DEATH

19 JULY 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HAMILTON NURSING HOME  
4212 PARKMONT AVE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto

19-05

D. STREET ADDRESS (If rural, give location)

329 S Stucker

c. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

May 20 1870

9. AGE (In years last birthday)

80

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

B. F. O. Gachard

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

John Stemler

14. MOTHER'S MAIDEN NAME

Mary Cassidy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

John Stemler 329 S Stucker

18. 4222 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)(A) MYOCARDITIS, CHRONIC AND  
DUE TO MYOCARDIAL DEGENERATION

INTERVAL BETWEEN ONSET AND DEATH

10945

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C) SEXILITY

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 MARCH, 1950 to 18 JULY, 1950, that I last saw the deceased alive on 18 JULY, 1950, and that death occurred at 4:20 A. M., from the causes and on the date stated above.

23A. SIGNATURE

C. S. Linn

23B. ADDRESS

M. D. 2074 E. BELVEDERE AVE.

23C. DATE SIGNED

7/19/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 20 1950

T. W. Williams, Jr.

Harry H. Metzger 4101 Edmonson

VS 150

937

MEDICAL CERTIFICATION

1945

1945

1945

1945

1945

1945

1945

1945

1945

1945

# CERTIFICATE CORRECTED 8-15-50

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 6327  
Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>RICHARD ROBINSON</b>			2. DATE OF DEATH <b>July 17, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harroll</b>					
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>US Marine Hospital</b> <b>Wyman Pk. Drive &amp; 31st St.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Westminster</b>					
c. Length of stay in Baltimore <b>?</b>			D. STREET ADDRESS (If rural, give location) <b>26 Charles Street</b> <b>5641</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>col</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Wid. Married</b>	8. DATE OF BIRTH <b>4/23/96</b>		9. AGE (In years last birthday) <b>54</b>		If Under 1 Year Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SEAFARER</b>			11. BIRTHPLACE (State or foreign country) <b>Va.</b>		
13. FATHER'S NAME <b>William Robinson</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>VW I</b>			17. INFORMANT ADDRESS <b>Records- US Marine Hospital, Balto, Md.</b>		

18. <b>492X 490X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Empyema, etiology not determined, right lung</b> DUE TO <b>Pericarditis, acute, hemorrhagic</b> (B) <b>Pneumonia, resolved, right upper</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>  <b>Unknown</b>  <b>(over)</b>
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19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 8, 1950</b> , to <b>July 17, 1950</b> , that I last saw the deceased alive on <b>July 17, 1950</b> , and that death occurred at <b>11:20A m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>D.W. Patrick, Medical Director</b>		23B. ADDRESS M. O. <b>US Marine Hospital, Balto, Md.</b>		23C. DATE SIGNED <b>7/18/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>7/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Md.</b>		25. FUNERAL DIRECTOR <b>Charles R. Law - 802 Mad. Ave.</b>		ADDRESS	

673 553 20

108

MEDICAL CERTIFICATION

RECEIVED  
CENTRAL  
DEPT. OF HEALTH

RECEIVED  
DEPT. OF HEALTH

*Leishmania*  
*elephas* corrected

from Bureau of Comm. Dis  
and report from Dr. John Berman  
US Marine Hosp

8.15.50 E.D. ...

626

6328

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

6328

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Helga Christina Berger

2. DATE OF DEATH

July 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

St. Joseph's Hospital

2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 24, 26-44

D. STREET ADDRESS (If rural, give location)

33 S. Kresson St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar 23rd 1929

9. AGE (In years last birthday)

21

10 Under 1 Year

Months

Days

11 Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR INDUSTRY

Goetze's

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August Schmuck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

George Berger

ADDRESS

3200 Brenden Ave

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

592X I

CAUSE OF DEATH

(A) Uremia

DUE TO Chronic glomerulonephritis

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

19. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒

NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

June 27, 1950, to

July 18, 1950

that I last saw the deceased alive on

July 18, 1950, and that death occurred at

2 P. m., from the causes and on the date stated above.

23A. SIGNATURE

B. B. Weber

M. D.

23B. ADDRESS

1400 N. Caroline St.

23C. DATE SIGNED

7/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Balto National

24D. LOCATION (City, town, or county) (State)

Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR

JUL 20 1950

VS 150

REGISTRAR'S SIGNATURE

Wmington Williams, M.D.

25. FUNERAL DIRECTOR

Lead. Brook 1701-03 R Patterson Park Ave

ADDRESS

690 40 3 2 7

131 B

626

6328

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

6328

Registered No.

1. NAME OF DECEASED  
(Type or Print)

Helga Christina Berger

2. DATE OF DEATH

July 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

St. Joseph's Hospital

2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 24, 26-44

D. STREET ADDRESS (If rural, give location)

33 S. Kresson St.

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Mar 23rd 1929

9. AGE (In years last birthday)

21

10 Under 1 Year

Months

Days

11 Under 24 Hours

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR INDUSTRY

Goetze's

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

August Schmuck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

George Berger

ADDRESS

3200 Brenden Ave

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

592X I

CAUSE OF DEATH

(A) Uremia

DUE TO Chronic glomerulonephritis

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

19. DATE OF OPERATION

2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒

NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

June 27, 1950, to

July 18, 1950

that I last saw the deceased alive on

July 18, 1950, and that death occurred at

2 P. m., from the causes and on the date stated above.

23A. SIGNATURE

B. B. Weber

M. D.

23B. ADDRESS

1400 N. Caroline St.

23C. DATE SIGNED

7/18/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 21, 1950

24C. NAME OF CEMETERY OR CREMATORY

Balto National

24D. LOCATION (City, town, or county) (State)

Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR

JUL 20 1950

VS 150

REGISTRAR'S SIGNATURE

Wmington Williams, M.D.

25. FUNERAL DIRECTOR

Lead. Brook 1701-03 R Patterson Park Ave

ADDRESS

690 40 3 2 7

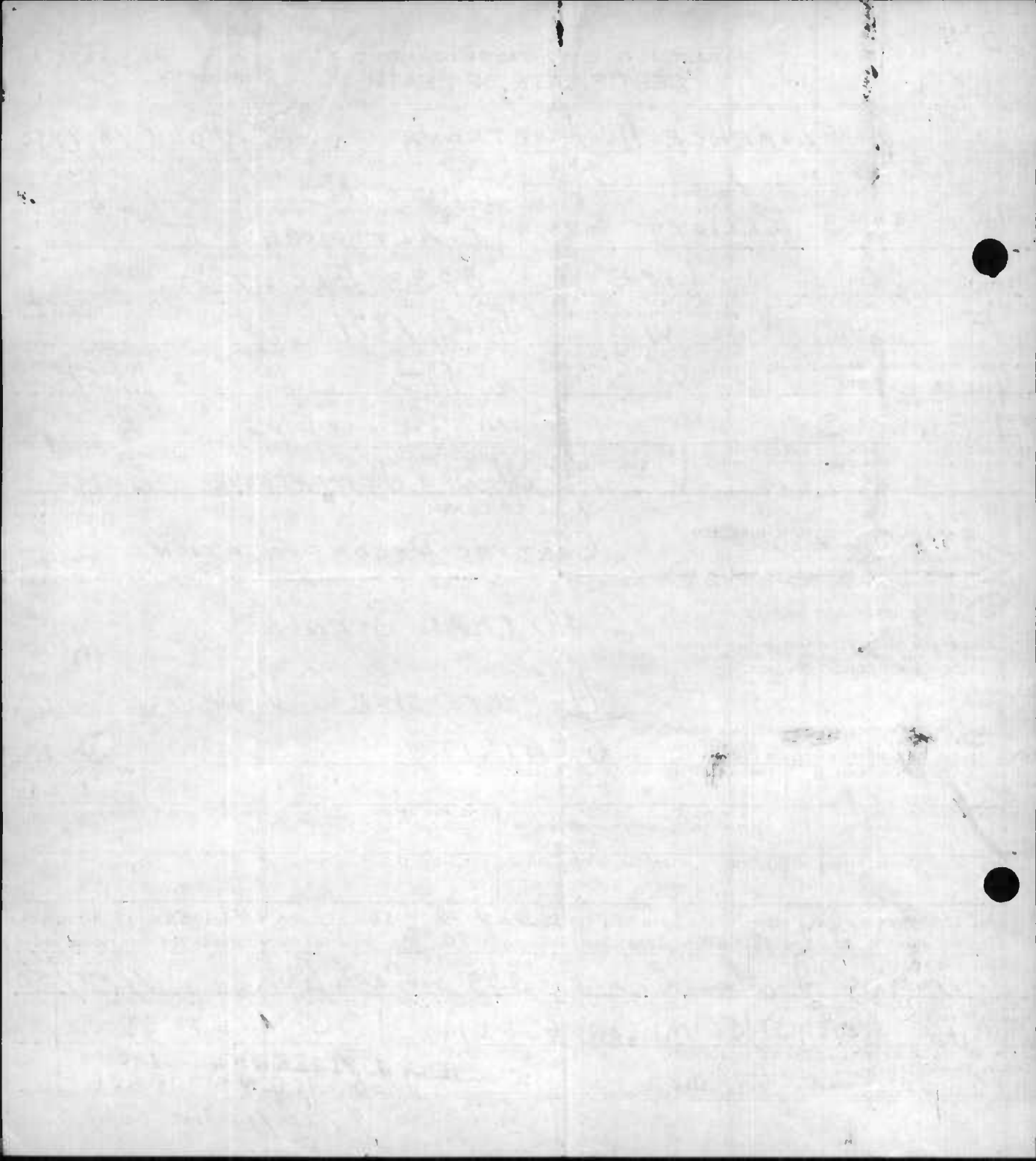
131 B

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634  
6329BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6329  
Registered No.

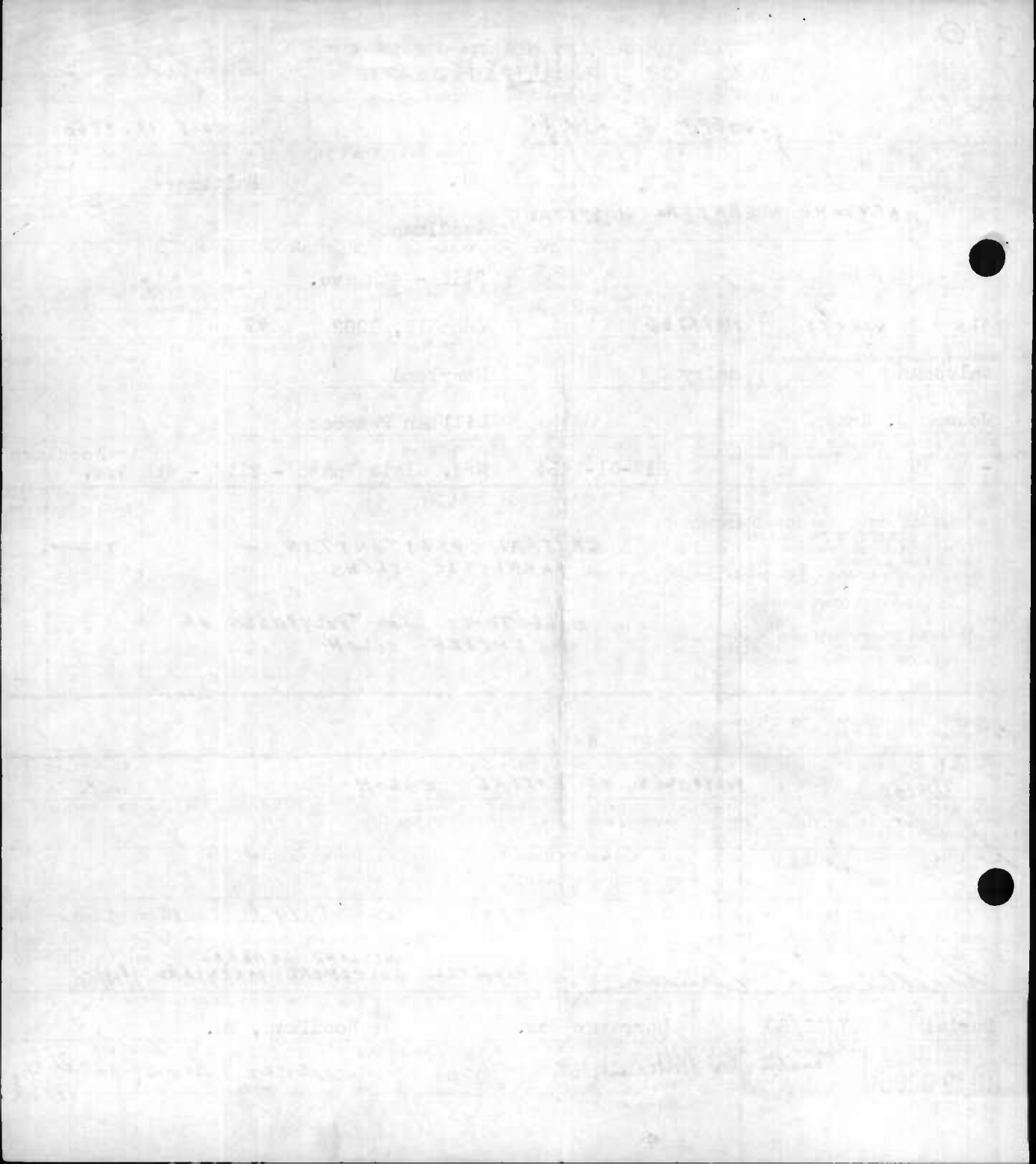
1. NAME OF DECEASED (Type or Print) <b>FLORENCE R. HARTLOVE</b>		2. DATE OF DEATH <b>JULY 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <b>BALTO. MD.</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) <b>3033 ELLIOTT ST.</b>		C. CITY OR TOWN (If outside corporate limits, write full name and give township) <b>BALTIMORE 1-00</b>	
C. Length of stay in Baltimore <b>LIFE</b>		D. STREET ADDRESS (If rural, give location) <b>3033 ELLIOTT ST.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>JAN. 27, 1871</b>
9. AGE (In years, last birthday) <b>79</b>		10. Under 1 Year: Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>WM ELWIE</b>		14. MOTHER'S MAIDEN NAME <b>MARY GWENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes, no or unknown</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HENRY J. HARTLOVE</b>		ADDRESS <b>SAME.</b>	
18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC DECOMPENSATION</b> DUE TO <b>M. TRAL STENOSIS</b> DUE TO <b>HYPERTENSIVE C. V. DISEASE</b> DUE TO <b>SENILITY.</b>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>JULY 18, 1950</b> to <b>JULY 18, 1950</b> that I last saw the deceased alive on <b>JULY 18, 1950</b> and that death occurred at <b>10:00 p.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Henry J. Houska</b>		23B. ADDRESS <b>333 S. East Ave.</b>	
23C. DATE SIGNED <b>7/18/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JULY 21/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>MT. CARMEL CEM</b>		24D. LOCATION (City, town, or county) (State) <b>ODONNELL ST</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>STEPHEN J. FIALKOWSKI, INC</b>		ADDRESS <b>1000 S. KENWOOD AVE</b>	
VS 150		<b>Stephen J. Fialkowski 92B</b>	



510  
50 6330BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6330

1. NAME OF DECEASED (Type or Print) <b>JOSEPH J. KNAPP</b>		2. DATE OF DEATH <b>JULY 19, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Woodlawn</b>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>2113 - 4th Ave. 5300</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>June 18, 1902</b>
9. AGE (In years last birthday) <b>47 48</b>		10. Under 1 Year Months: _____ Days: _____ 11. Under 24 Hours Hours: _____ Min: _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>salesman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>dairy (R)</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <b>Joseph J. Knapp</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Peacock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>217-01-1454</b>	
17. INFORMANT <b>Mrs. Elsie Knapp - 2113 - 4th Ave.</b>		ADDRESS <b>Woodlawn</b>	
1B. <b>211X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>(A) GENERAL PERITONITIS + PARALYTIC ILEUS</b> DUE TO <b>(B) COLECTOMY FOR POLYPOSES OF THE ENTIRE COLON.</b> DUE TO <b>(C) NONE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>NONE</b>			
19A. DATE OF OPERATION <b>7/15/50</b>		19B. MAJOR FINDINGS OF OPERATION <b>POLYPOSES OF ENTIRE COLON.</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>		21D. TIME (Month) (Day) (Year) (Hour) INJURY m. _____	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>3/31/1950</b> to <b>7/19/1950</b> , that I last saw the deceased alive on <b>7/19/1950</b> , and that death occurred at <b>1:22 a.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>William K. Brown</b> M. D.		23B. ADDRESS <b>MARYLAND GENERAL HOSPITAL. BALTIMORE. MARYLAND</b>	
23C. DATE SIGNED <b>7/19/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/22/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons, BALTO AND</b>	
25. FUNERAL DIRECTOR <b>Wm. J. Lickner &amp; Sons, BALTO AND</b>		ADDRESS <b>490 6B 56E</b>	



2-6  
AB-139822BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6331  
Registered No.

BIRTH NO. 6331

1. NAME OF DECEASED  
(Type or Print)

A. Walter Nelker

2. DATE  
OF  
DEATH

7-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR INSTITUTION Baltimore City Hospitals (location)  
4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Maryland

B. COUNTY

before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give

Baltimore

township)

D. STREET ADDRESS (If rural, give location)

5366 Cordelia St.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Upholsterer

10B. KIND OF BUSINESS OR  
INDUSTRY

Spring Bedding

13. FATHER'S NAME

John Fred Nelker

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(If yes, give war or dates of service)

none

16. SOCIAL  
SECURITY NO.

8. DATE OF BIRTH

March 25-1877

9. AGE (in years

last birthday)

73

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

17. INFORMANT Baltimore City Hospitals  
Records: 4940 Eastern Ave.

18. 332X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Cerebral Anoxia

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Cerebral Thrombosis

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING OR CONTRIBUTING  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-17-1950 to 7-19-1950, that I last saw the  
deceased alive on 7-19-1950 and that death occurred at 1.40AM, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

4940 Eastern Ave.

23C. DATE SIGNED

7-19-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/22/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 20 1950

Huntington Williams, M.D.

Thm. J. Pickner &amp; Sons, Balt. Md.

VS 150

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57 11 1964 21 25

• 11 1964 21 25

21 1964 21 25

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625  
60 6332BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6332

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HOWARD MORGAN

2. DATE  
OF  
DEATH

July 18, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

2800 Edmondson Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 16-06

D. STREET ADDRESS (If rural, give location)

2800 Edmondson Ave.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

July 20, 1875

9. AGE (In years,  
last birthday)

74

If Under 1 Year  
Months Days  
If Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)  
salesman10B. KIND OF BUSINESS OR  
INDUSTRY  
Wholesale Millinery

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George A. Morgan

14. MOTHER'S MAIDEN NAME

Annie Dorman

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Laura P. Morgan - 2800 Edmondson Ave

18. 4201 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, assthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-11-1949, to 7-18-50, 19\_\_, that I last saw the  
deceased alive on 11-21-49, and that death occurred at 3:40 a. m., from the causes and on the date stated above.

23A. SIGNATURE

Ruth S. Lemmel M. D.

23B. ADDRESS

2703 Edmondson

23C. DATE SIGNED

7-18-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/21/50

24C. NAME OF CEMETERY OR CREMATORY

Balto. Cem.

24D. LOCATION (City, town, or county) (State)

Balto., Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

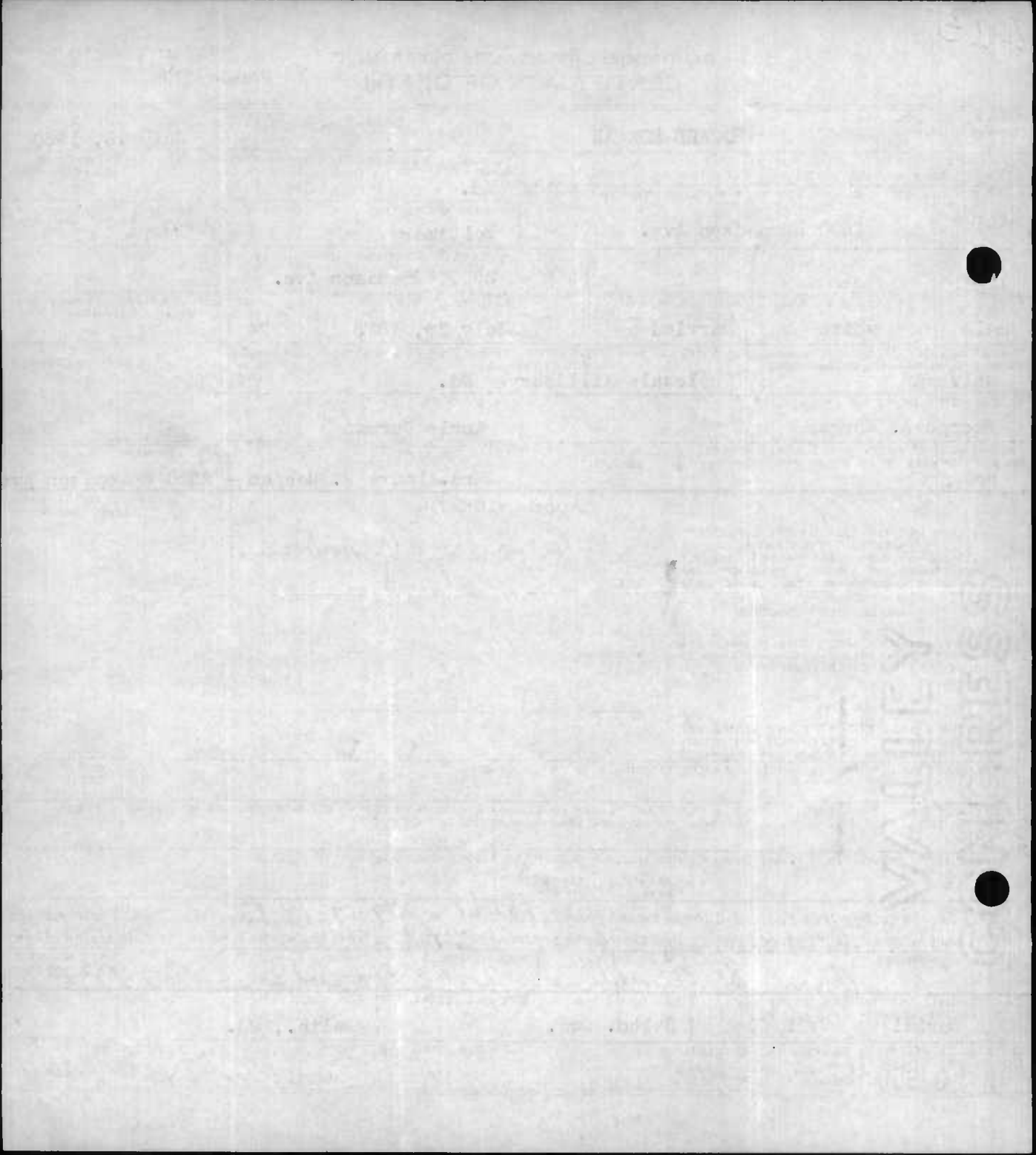
ADDRESS

Wm. J. Dickerson &amp; Sons Balto.

VS 150

490626331

94a Md.



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6333  
Registered No. \_\_\_\_\_

250  
6333  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>William MASON</u>				2. DATE OF DEATH <u>7/19/50</u>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <u>1613 E. Lafayette Ave - City -</u>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>8-06</u>			
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) <u>1613 E. Lafayette Ave</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Aug 15 1891</u>		9. AGE (In years last birthday) <u>58</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Woman's Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert Wm Mason</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Louison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Anna Mason 1613 E. Lafayette Ave</u>			

18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) <u>Myocardial Infarction due to atherosclerotic coronary thrombosis</u>		DUE TO		?	
(B) <u>Hypertensive C-V Disease</u>		DUE TO		?	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CERTIFICATION ATTENDED BY <u>R. S. Fisher</u> M. D. CHIEF OR ASST. MEDICAL EXAMINER	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <u>6</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>June</u> , 19 <u>49</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Mark E. Noel, Jr.</u> M. D.		23B. ADDRESS <u>Woman's Hosp -</u>		23C. DATE SIGNED <u>7/19/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>July 22 1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Western View</u>	
24D. LOCATION (City, town, or county) (State) <u>Edmondson Ave</u>		25. FUNERAL DIRECTOR <u>Leok Leok</u>		ADDRESS <u>1701-03 N. Patterson Park Ave</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 20 1950</u>		REGISTRAR'S SIGNATURE <u>Wm. H. Williams, M.D.</u>		26. <u>2 pronounced patient dead on arrival at 2:45 AM 7/19/50</u> <u>564 8T</u>	

MEDICAL CERTIFICATION

937

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of medical examiner		11. Signature of coroner		12. Signature of jury	
13. Signature of health officer		14. Signature of local health officer		15. Signature of local health officer		16. Signature of local health officer	
17. Signature of local health officer		18. Signature of local health officer		19. Signature of local health officer		20. Signature of local health officer	
21. Signature of local health officer		22. Signature of local health officer		23. Signature of local health officer		24. Signature of local health officer	
25. Signature of local health officer		26. Signature of local health officer		27. Signature of local health officer		28. Signature of local health officer	
29. Signature of local health officer		30. Signature of local health officer		31. Signature of local health officer		32. Signature of local health officer	
33. Signature of local health officer		34. Signature of local health officer		35. Signature of local health officer		36. Signature of local health officer	
37. Signature of local health officer		38. Signature of local health officer		39. Signature of local health officer		40. Signature of local health officer	
41. Signature of local health officer		42. Signature of local health officer		43. Signature of local health officer		44. Signature of local health officer	
45. Signature of local health officer		46. Signature of local health officer		47. Signature of local health officer		48. Signature of local health officer	
49. Signature of local health officer		50. Signature of local health officer		51. Signature of local health officer		52. Signature of local health officer	
53. Signature of local health officer		54. Signature of local health officer		55. Signature of local health officer		56. Signature of local health officer	
57. Signature of local health officer		58. Signature of local health officer		59. Signature of local health officer		60. Signature of local health officer	
61. Signature of local health officer		62. Signature of local health officer		63. Signature of local health officer		64. Signature of local health officer	
65. Signature of local health officer		66. Signature of local health officer		67. Signature of local health officer		68. Signature of local health officer	
69. Signature of local health officer		70. Signature of local health officer		71. Signature of local health officer		72. Signature of local health officer	
73. Signature of local health officer		74. Signature of local health officer		75. Signature of local health officer		76. Signature of local health officer	
77. Signature of local health officer		78. Signature of local health officer		79. Signature of local health officer		80. Signature of local health officer	
81. Signature of local health officer		82. Signature of local health officer		83. Signature of local health officer		84. Signature of local health officer	
85. Signature of local health officer		86. Signature of local health officer		87. Signature of local health officer		88. Signature of local health officer	
89. Signature of local health officer		90. Signature of local health officer		91. Signature of local health officer		92. Signature of local health officer	
93. Signature of local health officer		94. Signature of local health officer		95. Signature of local health officer		96. Signature of local health officer	
97. Signature of local health officer		98. Signature of local health officer		99. Signature of local health officer		100. Signature of local health officer	

620 139852 BIRTH NO. 50-14290		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		50 6334 Registered No.	
1. NAME OF DECEASED (Type or Print) Baby Girl Prescoe- Louise			2. DATE OF DEATH 7-17-50		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY 3-01		
5. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
6. Length of stay in Baltimore 1 hr			D. STREET ADDRESS (If rural, give location) 124 S. Caroline Ave.		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 17, 1950	9. AGE (In years last birthday)	10. Under 1 Year Months: Days 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Limon King			14. MOTHER'S MAIDEN NAME Louise Prescoe		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS B. C. H. Records, 4940 Eastern Ave.		
18. 750X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			CAUSE OF DEATH (A) Anoxia DUE TO (B) Anencephalic Monster DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 17, 1950, to July 17, 1950, that I last saw the deceased alive on July 17, 1950, and that death occurred at 4:30 AM, from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS 4940 Eastern Ave.		23C. DATE SIGNED 7-18-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) cremated		24B. DATE July 18, 1950	24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory	24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 19 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR ADDRESS	

State of California

AVANCE



200

6335

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6335

1. NAME OF DECEASED (Type or Print) <b>John Vincent Casey</b>		2. DATE OF DEATH <b>7/19/50</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHN JENKINS MEMORIAL HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>27-03</b>	
c. Length of stay in Baltimore <b>62</b>		d. STREET ADDRESS (If rural, give location) <b>3302 HILSA AVE</b>	
5. SEX <b>Male</b>	6. COLOR OF RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>7/19/1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		9. AGE (In years last birth day) <b>62 64</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>		11. BIRTHPLACE (State or foreign country) <b>BARYLAND</b>	
13. FATHER'S NAME <b>FRANK J. CASEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs. Thos. Keaune</b>		ADDRESS <b>430 E. 22nd ST.</b>	
18. <b>444X</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Arterio Sclerosis</b>	
DUE TO		<b>HYPERTENSION</b>	
ANTECEDENT CAUSES		(B) <b>PULMONARY EDEMA</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		DUE TO	
II		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/19, 1950</b> , to <b>7/19, 1950</b> that I last saw the deceased alive on <b>7/19, 1950</b> , and that death occurred at <b>4:40 P.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>John C. Stealy, Jr.</b>		23B. ADDRESS <b>St. Louis Hosp.</b>	
23C. DATE SIGNED <b>7/19/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>July 22, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Calverton Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, Jr.</b>	
25. FUNERAL DIRECTOR <b>Chas. F. Evans &amp; Son</b>		ADDRESS <b>5124M 118th Mt Royal Ave 97</b>	



310		S-316		63365-361		BALTIMORE CITY HEALTH DEPARTMENT		50 6336	
BIRTH NO.		CERTIFICATE CORRECTED		7-21-50		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		Also known as Mike Stavrou or Mike Michael Stere Stauroopoulos				2. DATE OF DEATH		7-16-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore				C. CITY OR TOWN Baltimore		2-03	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital		D. STREET ADDRESS (If rural, give location) 737 South Broadway				E. AGE (In years last birthday)		50	
c. Length of stay in Baltimore		Yrs. Mos. Days		F. DATE OF BIRTH Dec. 11-1899		G. AGE (In years last birthday)		50	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		H. Under 1 Year Months: Days		I. Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Stavros Karagiannis		14. MOTHER'S MAIDEN NAME Maria Kosma				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 232-03-4690	
17. INFORMANT Bill Eliades		ADDRESS 939 S. Oldham St				18. 526 X I		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Empyema, LEFT				DUE TO		BRONCHOPLEURAL FISTULA, post	
ANTECEDENT CAUSES		(B) pneumonia, left				DUE TO		BRONCHIECTASIS, lt + rt lower lobes	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) Congestive heart failure				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 6/30/50		19B. MAJOR FINDINGS OF OPERATION Bronchiectasis, lt. lower lobe lt. lung				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED	
21F. HOW DID INJURY OCCUR?		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from 7/16, 1950, to 7/16, 1950, that I last saw the deceased alive on 7/16, 1950, and that death occurred at 2:00 A.M., from the causes and on the date stated above.		23A. SIGNATURE R. Raming		23B. ADDRESS St. Agnes Hospital		23C. DATE SIGNED 7/17/50			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/20/50		24C. NAME OF CEMETERY OR CREMATORY Greek Orthodox		24D. LOCATION (City, town, or county) Baltimore Co. Md.			
DATE RECEIVED BY LOCAL REGISTRAR JUL 20 1950		REGISTRAR'S SIGNATURE William H. Williams		25. FUNERAL DIRECTOR George S. Agnew General Home		ADDRESS 118 W. Mt. Royal Ave		106 B	
VS 150		7846M		118 W. Mt. Royal Ave		106 B			



550

6337

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6337

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

FRANK J. SCHUMANN

2. DATE  
OF  
DEATH July 18, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 626 S. Eaton St.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR  
INDUSTRY

Steel-Worker

13. FATHER'S NAME

Frank F. Schumann

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
213-09-0564

8. DATE OF BIRTH

Feb. 1, 1887

9. AGE (In years  
last birthday)

63

If Under 1 Year  
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Anna Schleret

17. INFORMANT

ADDRESS

Mrs. Amelia Schumann 626 S. Eaton St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1946 to July 18, 1950, that I last saw the  
deceased alive on July 18, 1950 and that death occurred at 8:55 P.M. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 22 1950

24C. NAME OF CEMETERY OR CREMATORY

Sacred Heart Cemetery

24D. LOCATION (City, town or county) (State)

4701 German Hill Rd. Balto. Co. Md.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 20 1950

Wilmington Williams, M.D.

Charles J. Zeile

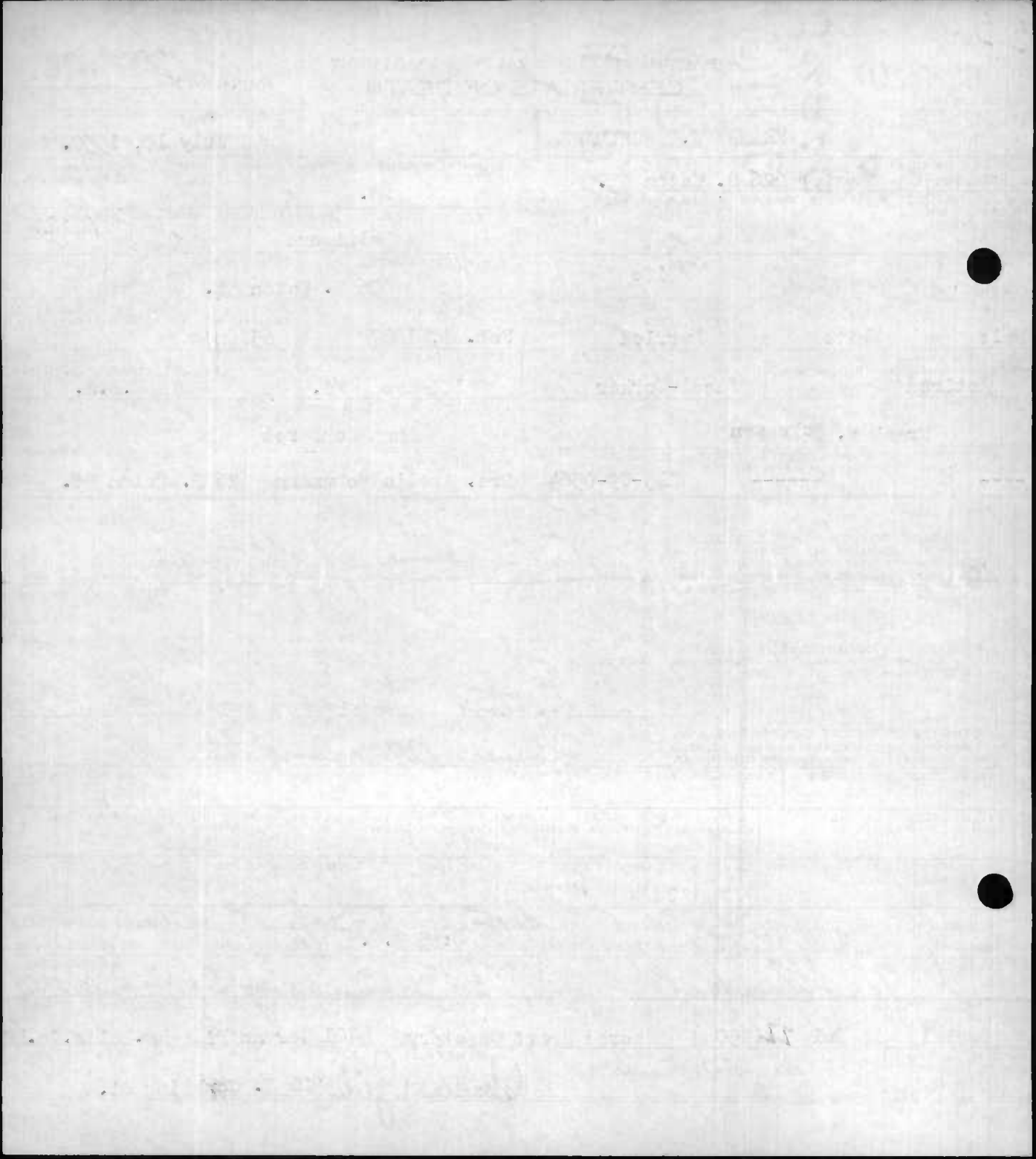
901 S. Conkling St.

VS 150

6903A

46B

MEDICAL CERTIFICATION





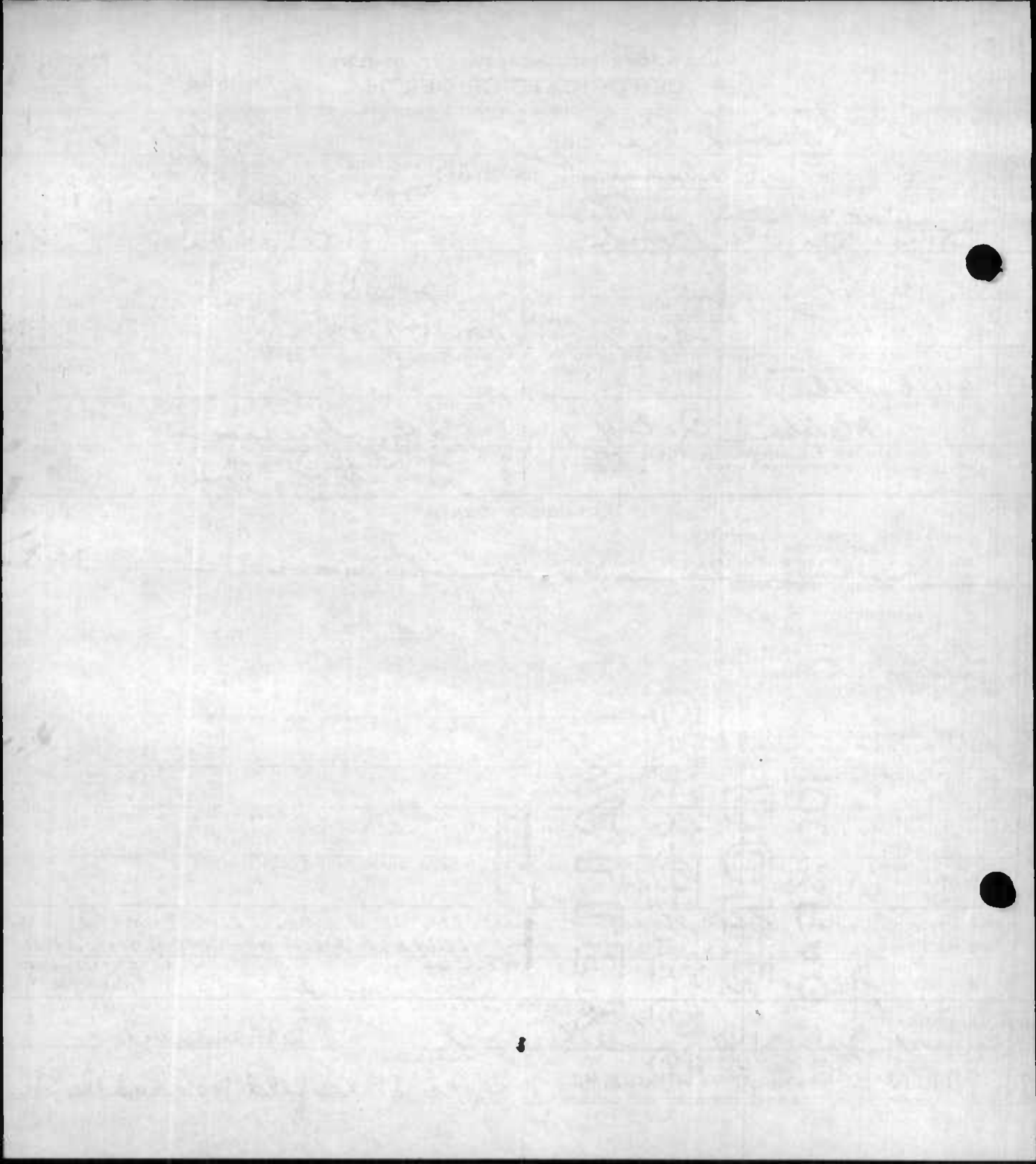
400  
6338BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6338

1. NAME OF DECEASED (Type or Print) <i>Frank Riley</i>		2. DATE OF DEATH <i>July 19, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>10-01</i>	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Stell's Lumber</i> <i>Home for the Aged</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
6. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <i>1200 Valley St</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>S.</i>	8. DATE OF BIRTH <i>Nov. 15, 1873</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years, last birthday) <i>76</i>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Michael Riley</i>		14. MOTHER'S MAIDEN NAME <i>Cath. Gilson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		17. INFORMANT <i>Stell's Lumber</i> ADDRESS <i>1200 Valley St.</i>	
16. SOCIAL SECURITY NO.			

18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocarditis</i> DUE TO ANTECEDENT CAUSES <i>Arterio Sclerosis</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <i>Myocarditis</i> <i>Arterio Sclerosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan. 10, 1950</i> , to <i>July 19, 1950</i> , that I last saw the deceased alive on <i>July 19, 1950</i> , and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph Fisher</i>		23B. ADDRESS <i>1823 N. East St.</i>		23C. DATE SIGNED <i>7/20/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 21/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>					
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 20 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Rita Wiedefeld</i>	
				ADDRESS <i>906 E. Biddle St</i>	



To be Approved by Chief Medical Examiner

6339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 6339

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **MOLLIE WILSON BERRY (MRS. HOPPER)**

2. DATE OF DEATH **JULY 19, 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **MARYLAND** B. COUNTY **Baltimore**

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**UNION MEMORIAL HOSPITAL**

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**COCKEYSVILLE 5300**

7. STREET ADDRESS (If rural, give location)  
**OFFUTT NURSING HOME**

8. Length of stay in Baltimore **BORN IN BALT.**

9. SEX **F** 10. COLOR OR RACE **W** 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **WIDOWED**

12. DATE OF BIRTH **6 Nov. 1859** 13. AGE (In years last birthday) **90**

14. BIRTHPLACE (State or foreign country) **BALT. MARYLAND** 15. CITIZEN OF WHAT COUNTRY? **U.S.A.**

16. FATHER'S NAME **YOUNG O. WILSON** 17. MOTHER'S MAIDEN NAME **SUSAN REESE**

18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) **No** 19. SOCIAL SECURITY NO.

20. INFORMANT ADDRESS **LYDIA BERRY, LUTHERVILLE, MD.**

21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
**Hypostatic Pneumonia**

22. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.)  
**Fracture, neck, Left Femur.**

23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

24. CERTIFICATION APPROVED BY **P. H. Fisher** M.D.  
CHIEF OR ASST. MEDICAL EXAMINER.

25. DATE OF OPERATION **July 15, 1950** 26. MAJOR FINDINGS OF OPERATION **Fracture, neck, Left Femur.**

27. AUTOPSY? YES ☒ NO ☐

28. ACCIDENT, SUICIDE, HOMICIDE (Specify) **Acc.** 29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Nursing Home**

30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **OFFUTT NURSING HOME, Cockeysville**

31. TIME (Month) (Day) (Year) (Hour) **July 15 1950 9:30 A.M.** 32. INJURY OCCURRED **Fell 2nd floor while getting out of bed**

33. HOW DID INJURY OCCUR? **FALL IN HOME.**

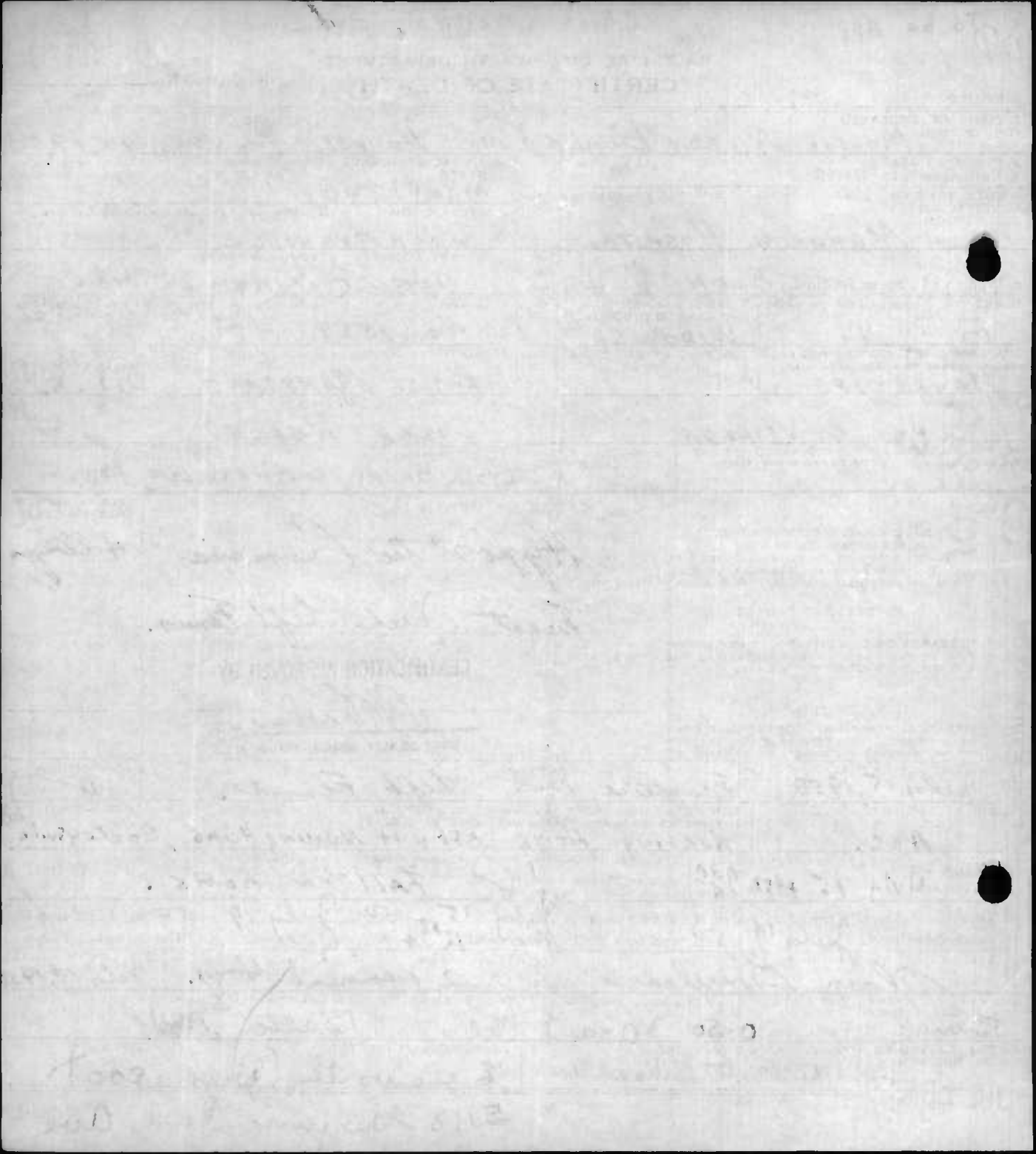
34. I hereby certify that I attended the deceased from **July 15, 1950**, to **July 19, 1950**, that I last saw the deceased alive on **July 19, 1950**, and that death occurred at **12:15 A.M.**, from the causes and on the date stated above.

35. SIGNATURE **Alvin Bongelaar** M.D. 36. ADDRESS **Union Memorial Hosp.** 37. DATE SIGNED **July 19, 1950**

38. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 39. DATE **July 20-50** 40. NAME OF CEMETERY OR CREMATORY **Mount Olivet** 41. LOCATION (City, town, county) (State) **Balto Md.**

42. DATE RECEIVED BY LOCAL REGISTRAR **JUL 20 1950** 43. REGISTRAR'S SIGNATURE **Thurston Williams, M.D.** 44. FUNERAL DIRECTOR ADDRESS **E. Leaworth Annacost**

45. **5118 Surgeon Oak Ave 186a**



J-212  
50 6340CERTIFICATE CORRECTED  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6340

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HIRAM E. JACOBS</b>			2. DATE OF DEATH <b>July 17, 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Foot of Wills Street</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>9-08</b>		
C. Length of stay in Baltimore <b>Abt. 15 yrs.</b> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>522 E. 20th Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 16, 1897</b>	9. AGE (In years last birthday) <b>53 52</b>	If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>House Painter</b>	11. BIRTHPLACE (State or foreign country) <b>Byron, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Christian E. Jacobs</b>			14. MOTHER'S MAIDEN NAME <b>Bessie Nederhoff</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mrs. Bessie Wheatley, Rhodesdale, Md. R.F.D.</b>		

18. <b>E919.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Drowning (Found drowned)</b> (A) <b>DEATH</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Acute alcoholism</b> (B) <b>DUE TO</b>	
(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Harbor</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Water at foot of Wills Street</b> <b>3/2</b>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 17, 1950 12:30 P.m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Found drowned</b>	
22. I certify that I took charge of the remains described above, held an <b>Inspection &amp; Inquiry</b> and Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , <u>undetermined</u> <input checked="" type="checkbox"/> .					
23A. SIGNATURE <b>Stanley H. Duncker</b> M.D.		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 18, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>East new market</b>	
24D. LOCATION (City, town, or county) (State) <b>East new market Md.</b>					

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>22 Frampton St Federal Shave</b>	
VS 151		N 99 X		56424	
				Md. 183	





G-65 50

6341

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6341  
Registered No.

BIRTH NO.			1. NAME OF DECEASED (Type or Print) <b>CHARLES R. GREENWALD</b>			2. DATE OF DEATH <b>July 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>					
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Randalstown</b>					
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>Chapman Road</b>					
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S</b>	8. DATE OF BIRTH <b>Oct. 14, 1942</b>	9. AGE (In years last birthday) <b>8 7</b>	If Under 1 Year Months: Days: Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Randallstown, Md.</b>		
13. FATHER'S NAME <b>Charles J. Greenwalt</b>			14. MOTHER'S MAIDEN NAME <b>Hilda M. Nickolas</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>L</b>			16. SOCIAL SECURITY NO. <b>L</b>			17. INFORMANT ADDRESS <b>Charles J. Greenwalt, Randallstown</b>		
18. <b>EE 17.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Multiple abrasions and contusions with fracture of left tibia</b> DUE TO <b>(A)</b> DUE TO <b>(B)</b> DUE TO <b>(C)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(II)</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>9</b>			19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Liberty Road near Warts Chapel Road</b>		
21D. TIME (Month) (Day) (Year) (Hour) <b>July 19, 1950 8.00 p.m.</b>			21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR? <b>Pedestrian struck by automobile</b> <b>5300</b>		
22. I certify that I took charge of the remains described above, held an <b>Inquiry &amp; Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .								
23A. SIGNATURE <b>William I. Smith</b>						23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		
23C. DATE SIGNED <b>July 20, 1950</b>								
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>7/22/1950</b>			24C. NAME OF CEMETERY OR CREMATORY <b>Holy Family</b>		
24D. LOCATION (City, town, or county) (State) <b>Randallstown, MD</b>			24E. FUNERAL DIRECTOR <b>Frank H. Newell, Pikesville, Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>Ms 20 1950</b>			REGISTRAR'S SIGNATURE <b>Thurston Williams, MD</b>			ADDRESS <b>170c</b>		

CERTIFICATE OF DEATH

*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for personal information, cause of death, and official signatures.]*

NAME OF DECEASED: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

SIGNATURE OF PHYSICIAN: \_\_\_\_\_

SIGNATURE OF REGISTRAR: \_\_\_\_\_

H-635  
50 6342

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X 50 6342  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>VERNE HARDAMAN</b>		2. DATE OF DEATH <b>July 18 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>md</b> b. COUNTY <b>Balto.</b>			
b. FULL NAME OF (If not in hospital or institution, give street address or location) <b>ELIOT HOSPITAL, Baltimore md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Pikesville</b>			
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>604 Rustington Rd. 5200</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>about 51 yrs.</b>	9. AGE (In years last birthday) <b>51</b>	10. Under 1 Year Months: Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Cleveland Ohio</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Quinn</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Samuel Hardaman, Baltimore</b>			

18. <b>410X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b> DUE TO <b>Mitral insufficiency</b> DUE TO <b>Severe Aortic Fibriation</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Thyroid</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>July 17, 1950</b> , to <b>July 18, 1950</b> , that I last saw the deceased alive on <b>July 18, 1950</b> , and that death occurred at <b>1:45 P.M.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>Frank H. Winter</b>	23B. ADDRESS <b>Smalls House, Baltimore</b>	23C. DATE SIGNED <b>July 18 50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/21/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Charles</b>	24D. LOCATION (City, town, or county) (State) <b>Pikesville, md</b>
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <b>Frank H. Winter</b>	25. FUNERAL DIRECTOR <b>Frank H. Winter</b>	
JUL 20 1950		7208A 34 92B md	



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6343

GROOM

50 6343

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Anna Groom*2. DATE  
OF  
DEATH

July 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

3328 Fleet Street

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

April 2, 1883

9. AGE (In years  
last birthday)

67

If Under 1 Year  
Months: Days: Hours: Min.12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

own home

13. FATHER'S NAME

John Spann

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

14. MOTHER'S MAIDEN NAME

Minnie Dosch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Conrad Groom, 3328 Fleet Street

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

DUE TO

(A) Cerebral hemorrhage

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(B) Hypertensive Cardiovascular  
Disease

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-15, 1950, to 7/19, 1950, that I last saw the  
deceased alive on 7/19, 1950, and that death occurred at 8:34 p.m., from the causes and on the date stated above.

23A. SIGNATURE

*Jerome Gaber*

M. O.

23B. ADDRESS

Lutheran Hosp.

23C. DATE SIGNED

7/20/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

burial

24B. DATE

7/22/50

24C. NAME OF CEMETERY OR CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Huntington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

Stm. Cook, Inc. 1217 St. Paul Street

CERTIFICATE OF DEATH

WARD

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50 6344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 6344

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

EMMA L. GAMBLE

2. DATE OF DEATH

July 19, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

5. C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

6. D. STREET ADDRESS (If rural, give location)

1533 Cole St.

7. Length of stay in Baltimore

Life

8. SEX

F

9. COLOR OR RACE

W

10. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

11. DATE OF BIRTH

Aug. 14, 1893

12. AGE (In years last birthday)

56

13. If Under 1 Year

11 Months

14. If Under 24 Hours

25 Hours

15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Charlady, Western Nat. Bank, RETired

16. KIND OF BUSINESS OR INDUSTRY

17. BIRTHPLACE (State or foreign country)

Baltimore

18. CITIZEN OF WHAT COUNTRY?

19. FATHER'S NAME

George Scheib

20. MOTHER'S MAIDEN NAME

Emma Shipley

21. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

22. SOCIAL SECURITY

218-14-3492

23. INFORMANT

Elsie Gerlack

24. ADDRESS

1725 Lemmon St.

25. CAUSE OF DEATH

(A) Skull fracture

26. DUE TO

27. ANTECEDENT CAUSES

(B) Multiple rib fractures with contusions of chest

28. DUE TO

29. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.

(C) Glaucoma with near blindness

30. 19A. DATE OF OPERATION

31. 19B. MAJOR FINDINGS OF OPERATION

32. 20. AUTOPSY?

YES

NO

33. 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Cole and Perry Sts.

21D. TIME (Month) (Day) (Year) (Hour)

July 19, 1950 7:45

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

34. 22. I certify that I took charge of the remains described above, held an Inspection & Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

35. 23A. SIGNATURE

R. Fisher

36. 23B. CHIEF MEDICAL EXAMINER

37. 23C. DATE SIGNED

July 19, 1950

38. 24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

39. 24B. DATE

July 22, 1950

40. 24C. NAME OF CEMETERY OR CREMATORY

Louisa Park

41. 24D. LOCATION (City, town, or county) (State)

Baltimore

42. DATE RECEIVED BY LOCAL REGISTRAR

43. REGISTRAR'S SIGNATURE

44. 25. FUNERAL DIRECTOR

45. ADDRESS

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CERTIFICATE OF DEATH

1915

DECEASED

DECEASED

DECEASED

DECEASED

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6345

415 0 6345 BIRTH NO.		I. NAME OF DECEASED (Type or Print) <u>Joseph A. HLAVIN Sr.,</u>		2. DATE OF DEATH <u>19 July 50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Sinai Hosp</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balto, Md.</u> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>			
C. Length of stay in Baltimore <u>life</u>		D. STREET ADDRESS (If rural, give location) <u>2721 E. Madison St.,</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <u>Sept 23, 1871</u>	9. AGE (In years last birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired, Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Goldman Clorthing Co</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Joseph Hlavin</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Marie A. Munaw, 2717 E. Madison St</u>	

18. <u>610X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>UREMIA</u>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO <u>Pyonephrosis - bilateral</u>		
(B) DUE TO <u>vascular neck obstruction</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <u>6 June 50</u>		19B. MAJOR FINDINGS OF OPERATION <u>Prostatic Hypertrophy</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>no</u>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>no</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>no</u>	
21D. TIME (Month) (Day) (Year) (Hour) INJURY <u>no</u>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>no</u>	
22. I hereby certify that I attended the deceased from <u>29 June</u> , 19 <u>50</u> , to <u>19 July</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>19 July</u> , 19 <u>50</u> , and that death occurred at <u>12:50 a. m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>T. J. Scherlis</u>		23B. ADDRESS <u>SINAI Hospital</u>		23C. DATE SIGNED <u>19 July 50</u>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/22/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Belair Rd.,</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 20 1950</u>		REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>Schimunek Funeral Home Inc</u>		ADDRESS <u>2601 E. Madison St.</u>	
<u>Charles C. Schimunek 137a</u>							

MEDICAL CERTIFICATION

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

LOCATION: \_\_\_\_\_

REMARKS: \_\_\_\_\_

REMARKS: \_\_\_\_\_

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6346

Registered No. \_\_\_\_\_

200  
50 6346  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mary J. Roggio</b>		2. DATE OF DEATH <b>July 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>4700 Harford Rd.,</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Harford Convalescent Home</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>33yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>613 N. Belnord Ave.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>March 14, 1869</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife at home</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years last birthday) <b>81</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
13. FATHER'S NAME <b>Joseph Buscemi</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Joseph Roggio, 1801 E. Lafayette Ave #13</b>	
13. FATHER'S NAME <b>Joseph Buscemi</b>		14. MOTHER'S MAIDEN NAME <b>Grace Pigna</b>	

<p>18. <b>442 X</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>CAUSE OF DEATH</b></p> <p>(A) <b>Arterio Sclerotic Cardio-Vascular</b> DUE TO <b>Renal Disease</b></p> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>4 yrs</b></p> <p><b>ANTECEDENT CAUSES</b></p> <p>(B) _____ DUE TO _____</p> <p>(C) _____</p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b></p>	<p>19A. DATE OF OPERATION <b>0</b></p> <p>19B. MAJOR FINDINGS OF OPERATION</p> <p>20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
	<p>21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)</p> <p>21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
	<p>21D. TIME (Month) (Day) (Year) (Hour) INJURY</p> <p>21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>21F. HOW DID INJURY OCCUR?</p>	
	<p>22. I hereby certify that I attended the deceased from <b>7-12</b>, 19<b>50</b>, to <b>7-18</b>, 19<b>50</b>, that I last saw the deceased alive on <b>7-17</b>, 19<b>50</b>, and that death occurred at <b>6:20 a.m.</b>, from the causes and on the date stated above.</p>	

23A. SIGNATURE <b>A. D. Lynn M. D.</b>		23B. ADDRESS <b>11 E. Chase St.</b>		23C. DATE SIGNED <b>7/19/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/21/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	
24D. LOCATION (City, town, or county) <b>Belair Road, Balto, Md.</b>		(State) _____			

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Schimunek Funeral Home 2601-5 E. Madison St.</b>	
VS 150		<p align="right"><b>Charles P. Schimunek 131a</b></p>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Toxicologist

Signature of Forensic Anthropologist

Signature of Forensic Psychologist

Signature of Forensic Linguist

Signature of Forensic Artist

Signature of Forensic Photographer

Signature of Forensic Scientist

Signature of Forensic Engineer

Signature of Forensic Chemist

Signature of Forensic Biologist

Signature of Forensic Geologist

Signature of Forensic Meteorologist

Signature of Forensic Astronomer

Signature of Forensic Historian

Signature of Forensic Archaeologist

Signature of Forensic Anthropologist

Signature of Forensic Psychologist

Signature of Forensic Linguist

Signature of Forensic Artist

Signature of Forensic Photographer

Signature of Forensic Scientist

Signature of Forensic Engineer

Signature of Forensic Chemist



653			THORNTON			BALTIMORE CITY HEALTH DEPARTMENT			50 6347		
BIRTH NO.			6347			Registered No.			50 6347		
1. NAME OF DECEASED (Type or Print)						2. DATE OF DEATH					
Eliza J. Thornton						July 17, 1958					
3. PLACE OF DEATH:						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
A. Baltimore City, Maryland						A. STATE Maryland B. COUNTY					
B. FULL NAME OF (If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)					
930 W. Lexington St.						Baltimore 18-01					
C. Length of stay in Baltimore						D. STREET ADDRESS (If rural, give location)					
Yrs. Mos. Days						930 W. Lexington St.					
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Year Months: Days	
Female		C		Widow		Feb. 10, 1893		57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic								Elbridge, Md.		U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Elijah Crowner						Amanda Powell.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No.						Katie Wallace, 930 W. Lexington St.					
18. 420.0						CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)						(A) Intermittent Heart Disease					
ANTECEDENT CAUSES						DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.						(B) Melancholia					
II						(C) Melancholia					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION				19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?			
0								YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
INJURY				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
22. I hereby certify that I attended the deceased from 2/6/50 to 2/12/50, that I last saw the deceased alive on 2/12/50, and that death occurred at 8:30 PM on the causes and on the date stated above.											
23A. SIGNATURE						23B. ADDRESS			23C. DATE SIGNED		
Wm. Carner M. D.						203 Gay St			7/20/58		
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county)		24E. STATE			
Burial		7-20-1958		Mt. Auburn Cem.		Balto.		Md.			
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR			ADDRESS		
JUL 20 1958		Wm. J. Williams, M.D.				Mrs. Kate R. Williams			Schweden St.		
VS 150											
720 FA 6340 937											

Elmer J. Thompson

Assistant Attorney General

Washington, D.C.

Dear Sir:

Enclosed for you are

two copies of the

report of the

Commission on

the Administration of

Justice.

Very respectfully,

Elmer J. Thompson

Assistant Attorney General

Washington, D.C.

Very truly yours,

Elmer J. Thompson

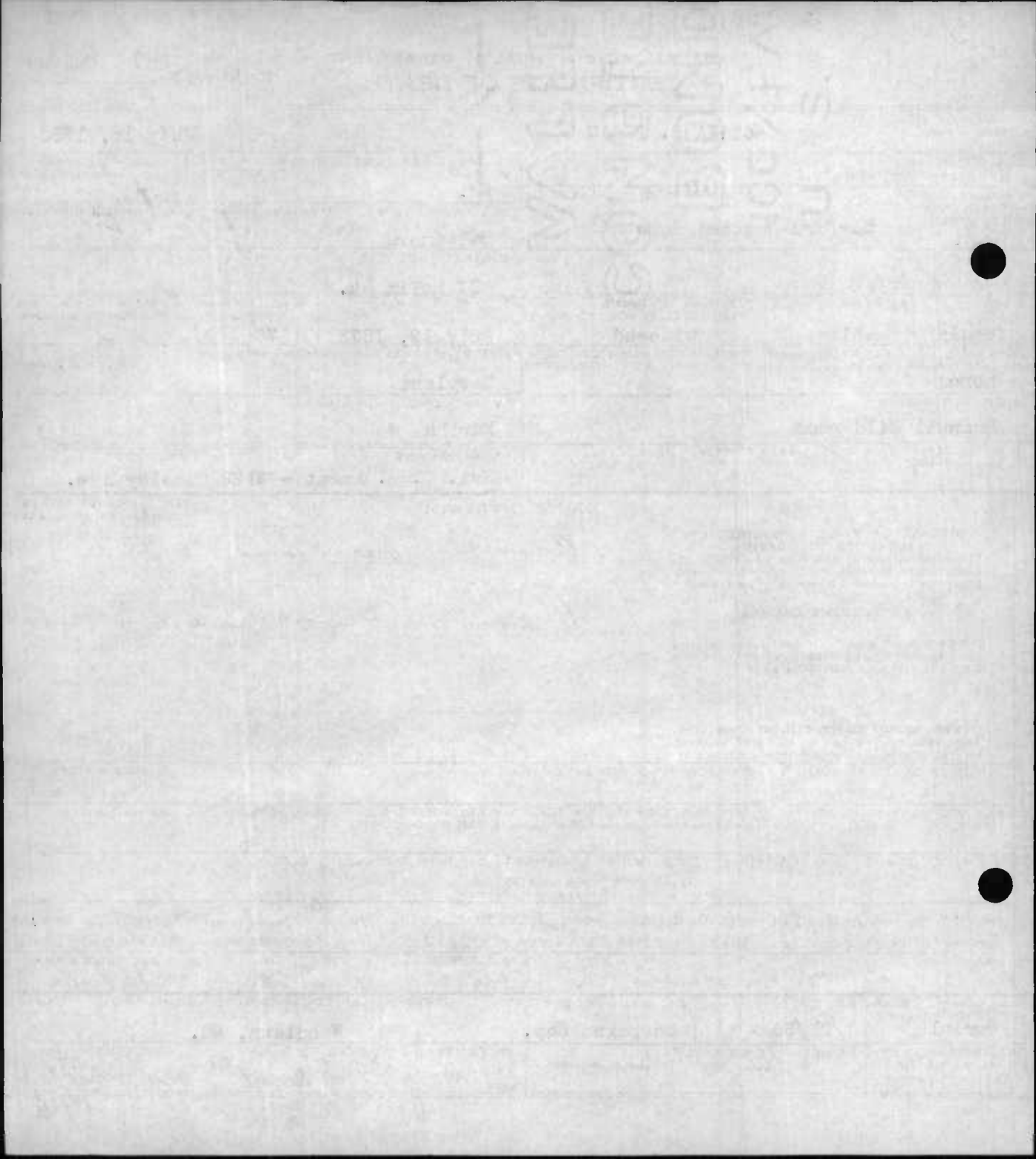
Assistant Attorney General

250  
6348

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6348

1. NAME OF DECEASED (Type or Print)		CLARA B. TYSON		2. DATE OF DEATH July 18, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION Harford Nursing Home				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location) 837 McKim St.	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 19, 1873		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			9. AGE (In years: last birthday) 76		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Emanuel Wilderson			12. CITIZEN OF WHAT COUNTRY? Maryland		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			14. MOTHER'S MAIDEN NAME Martha ?		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mrs. C. A. Ament - 3129 Chesley Ave.		
18. 421.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Broncho Pneumonia DUE TO (B) Valvular Heart disease DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos.					
19A. DATE OF OPERATION 0				19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 6, 1950, to July 18, 1950, that I last saw the deceased alive on July 18, 1950, and that death occurred at 4 p.m., from the causes and on the date stated above.					
23A. SIGNATURE Jacob Fisher		23B. ADDRESS 1823 N. West St. M. D.		23C. DATE SIGNED 7/19/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/21/50		24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem.	
24D. LOCATION (City, town, or county) Woodlawn, Md.		24E. DATE RECEIVED BY LOCAL REGISTRAR JUL 20 1950		24F. REGISTRAR'S SIGNATURE Huntington Williams, Jr.	
24G. FUNERAL DIRECTOR Wm. J. Sicker & Sons, Balto		24H. ADDRESS 927 md.		24I. 6347	



200

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6349

Registered No. \_\_\_\_\_

BIRTH NO. 6349

1. NAME OF DECEASED (Type or Print) <b>WILLIAM POUTNEY COCKEY</b>			2. DATE OF DEATH <b>JULY 19, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 27-12</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>			D. STREET ADDRESS (If rural, give location) <b>403 EVESHAM AVE., BALTO. 12, MD.</b>		
c. Length of stay in Baltimore <b>60</b>			Yrs. <b>60</b> Mos. <b>60</b> Days <b>60</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>MAY 6, 1890</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Year Months: <b>60</b> Days: <b>60</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION FOREMAN, BALTO. CITY</b>			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME <b>SAM COCKEY (D)</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>			16. SOCIAL SECURITY NO.		
14. MOTHER'S MAIDEN NAME <b>LAURA THOMAS (D)</b>			17. INFORMANT ADDRESS		

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY THROMBOSIS</b> DUE TO <b>HYPERTENSIVE - ARTERIO SCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 MINUTE</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CHRONIC ATRICULAR FIBRILLATION</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>JULY 18, 1950</b> , to <b>JULY 19, 1950</b> , that I last saw the deceased alive on <b>JULY 19, 1950</b> , and that death occurred at <b>4:45P m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Richard Beach</b>		23B. ADDRESS <b>Union Memorial Hospital</b>		23C. DATE SIGNED <b>7-19-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremial</b>		24B. DATE <b>7/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>		25. FUNERAL DIRECTOR <b>Wm. J. Pickens &amp; Sons, Balto Md.</b>			

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

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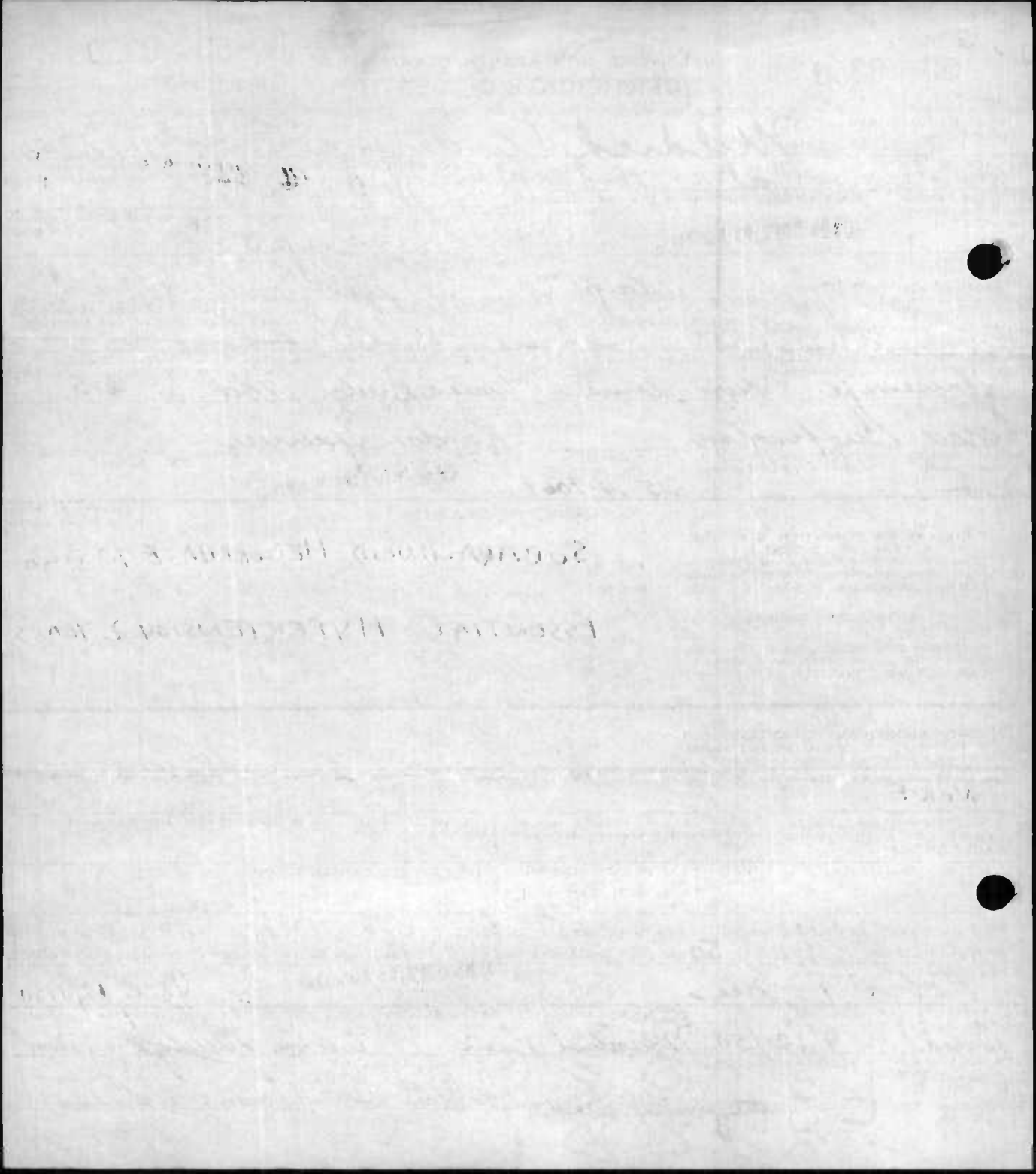
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50 6350		BALTIMORE CITY HEALTH DEPARTMENT		X 50 6350	
BIRTH NO.		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print)		Mildred Anderson		2. DATE OF DEATH July 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Anne Arundel		C. CITY OR TOWN Jessups	
5. FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL		D. STREET ADDRESS (If rural, give location) Guilford Road		E. CITY OR TOWN Jessups	
6. Length of stay in Baltimore 11 days		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 11-19-99	
9. SEX Female		10. COLOR OR RACE White		11. AGE (In years last birthday) 50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Non home		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oscear Buffington		14. MOTHER'S MAIDEN NAME Rhoda Spurrier		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or date of service) No	
16. SOCIAL SECURITY NO. 215-14-7569		17. INFORMANT JOHNS HOPKINS HOSPITAL		ADDRESS	
18. 330X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) SUBARACHNOID HEMORRHAGE 10 days		CAUSE OF DEATH (A) DUE TO (B) ESSENTIAL HYPERTENSION 2 YEARS (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION NONE		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-8-1950 to 7-19-1950, that I last saw the deceased alive on 7-19-1950 and that death occurred at 11:20 a.m., from the causes and on the date stated above.					
23A. SIGNATURE Robert T. Keen		23B. SIGNATURE JOHNS HOPKINS HOSPITAL		23C. DATE SIGNED July 17, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/22/50		24C. NAME OF CEMETERY OR CREMATORY Mountain View	
24D. LOCATION (City, town, or county) Union Bridge Md		24E. FUNERAL DIRECTOR The Will Geraldson Funeral Home		24F. ADDRESS	
25. DATE RECEIVED BY LOCAL REGISTRAR 201950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR The Will Geraldson Funeral Home	
VS 150		8342		83a	



400  
50 6351BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

X Registered No. 50 6351

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LAWRENCE

NEAL

2. DATE  
OF  
DEATH

July 20, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Johns Hopkins Hospital

Yrs.  
Mos.  
Days

c. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Divorced

8. DATE OF BIRTH

March 23, 1919

9. AGE (In years  
last birthday)

31

10. Under 1 Year  
Months: Days  
11. Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Tenant Farmer

10B. KIND OF BUSINESS OR  
INDUSTRY

Farm

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Adam Stanley Neal

14. MOTHER'S MAIDEN NAME

Anne Blanche Miner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212/4/6214

17. INFORMANT

ADDRESS

Ruby L. Coyle 137 Ray St. Hagerstown

18. E 900.0

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Skull fracture with subdural hematoma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (a. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

137 Ray Street, Hagerstown

21D. TIME (Month) (Day) (Year) (Hour)

INJURY  
July 8, 1950

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell down porch steps while drunk

22. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William Williams

M.D.

23b. CHIEF MEDICAL EXAMINER.....☐  
ASSISTANT MEDICAL EXAMINER.....☒  
MEDICAL INVESTIGATOR.....☐

23c. DATE SIGNED

July 20, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

Burial

July 24, 1950

24C. NAME OF CEMETERY OR CREMATORY

Lutheran Church Cemetery, Hagerstown, Maryland

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

William Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

Fred W. Kraiss, Hagerstown, Md.

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CENTRAL BANK DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6352  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Carrie Palmer. 343700</b>		2. DATE OF DEATH <b>JUL 18 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write ALLENTOWN and give township) <b>Baltimore 10-03</b>	
D. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		E. STREET ADDRESS (If rural, give location) <b>818 Somerset St.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>S.</b>	8. DATE OF BIRTH <b>8-18-11</b>
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		9B. KIND OF BUSINESS OR INDUSTRY <b>none</b>	9. AGE (In years last birthday) <b>38</b> If Under 1 Year: Months _____ Days _____ If Under 24 Hours: Hours _____ Min. _____
10. FATHER'S NAME <b>Sam Palmer.</b>		11. BIRTHPLACE (State or foreign country) <b>James Town S.C.</b>	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. SOCIAL SECURITY NO. _____		15. MOTHER'S MAIDEN NAME <b>Kizzie Bradford</b>	
16. INFORMED BY <b>JOHNS HOPKINS HOSPITAL</b>		17. ADDRESS _____	

<p>18. <b>604X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH</p> <p>(A) <b>Pylonephritis acute and pyonephrosis acute R.</b></p> <p>ANTECEDENT CAUSES</p> <p>(B) <b>Calculus at R. uretero pelvic junction 5d</b></p> <p>(C) <b>Rheumatic heart disease with mitral stenosis and mitral insufficiency</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><b>5d</b></p> <p><b>75 YRS</b></p>	

19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-15-1950</b> to <b>7-18-1950</b> that I last saw the deceased alive on <b>7-18-1950</b> , and that death occurred at <b>12:10 P.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Thomas E. Van Metre Jr.</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>18 July 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/21/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>James town South Carolina</b>	
24D. LOCATION (City, town, or county) (State) <b>South Carolina</b>		25. FUNERAL DIRECTOR <b>Johnnie Shaw 1408 Ashland Ave</b>		ADDRESS _____	

*[Faint, illegible handwriting throughout the page]*



100  
50 6353BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6353  
Registered No.

1. NAME OF DECEASED (Type or Print) MINNA J. LOBE			2. DATE OF DEATH JULY 19, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE UNION MEMORIAL HOSPITAL			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-15		
C. Length of stay in Baltimore 70 Yrs. Mos. Days.			D. STREET ADDRESS (If rural, give location) 5802 GREENSPRING AVE.		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAR. 29, 1880	9. AGE (In years last birthday) 70	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10B. KIND OF BUSINESS OR INDUSTRY		
13. FATHER'S NAME JACOB JACOBI (D)			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		

18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. HYPERTENSIVE-ARTEROSCLEROTIC HEART DISEASE. DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS	INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 3 YRS.
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19A. DATE OF OPERATION 0	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from JULY 17, 1950, to JULY 19, 1950, that I last saw the deceased alive on JULY 19, 1950, and that death occurred at 6:25 P.M., from the causes and on the date stated above.		
23A. SIGNATURE R. J. Bensch Jr.	23B. ADDRESS Union Memorial Hospital	23C. DATE SIGNED 7-19-50
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE July 20, 1950	24C. NAME OF CEMETERY OR CREMATORY Ches. Shalom
24D. LOCATION (City, town, or county) Home St	24E. FUNERAL DIRECTOR David S. Sandhu	24F. ADDRESS 1802 Entaw place

UNITED STATES DEPARTMENT OF THE ARMY  
CENTRAL FILE OF DATA

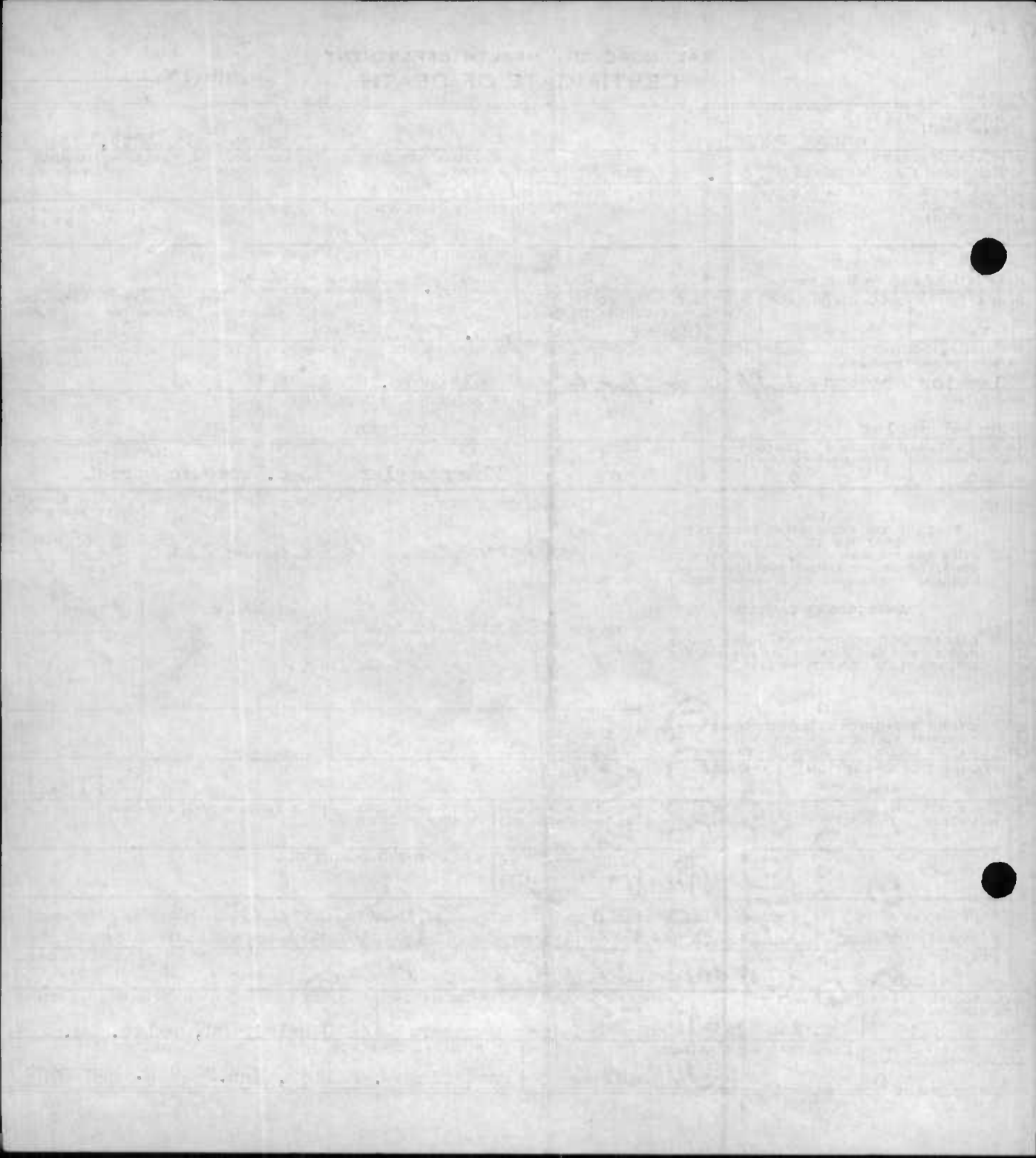
246  
50 6354BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6354  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MICHAEL REGLER</b>			2. DATE OF DEATH <b>July 18th, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2924 E. Fayette Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>6-01</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore city</b>		
c. Length of stay in Baltimore 84 Yrs. 5 Mos. 5 Days			D. STREET ADDRESS (If rural, give location) <b>2924 E. Fayette Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 23th 1866</b>	9. AGE (In years last birthday) <b>84</b>	10. Under 1 Year Months: <b>5</b> Days: <b>18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Elevator Erector (Retired)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>10 EIS &amp; Elev. Co.</b>		
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>		
13. FATHER'S NAME <b>Conrad Regler</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Elmer Regler</b>			ADDRESS <b>613 N. Potomac Street</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b> DUE TO (A) <b>Coronary Occlusion</b> DUE TO (B) <b>Degenerative Heart Disease</b> DUE TO (C) <b>Disease</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>?</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 15, 1950</b> to <b>July 18, 1950</b> that I last saw the deceased alive on <b>July 18, 1950</b> , and that death occurred at <b>1:30 am</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Francis J. Januszewski</b>		23B. ADDRESS <b>5440 N. Linwood</b>		23C. DATE SIGNED <b>7-20-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-22-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd, Balto. Md.</b>		25. FUNERAL DIRECTOR <b>Frederick D. Miller, Inc.</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 20 1950</b>		REGISTRAR'S SIGNATURE <b>Frederick D. Miller, Inc.</b>		ADDRESS <b>3019 E. Monument St</b>	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

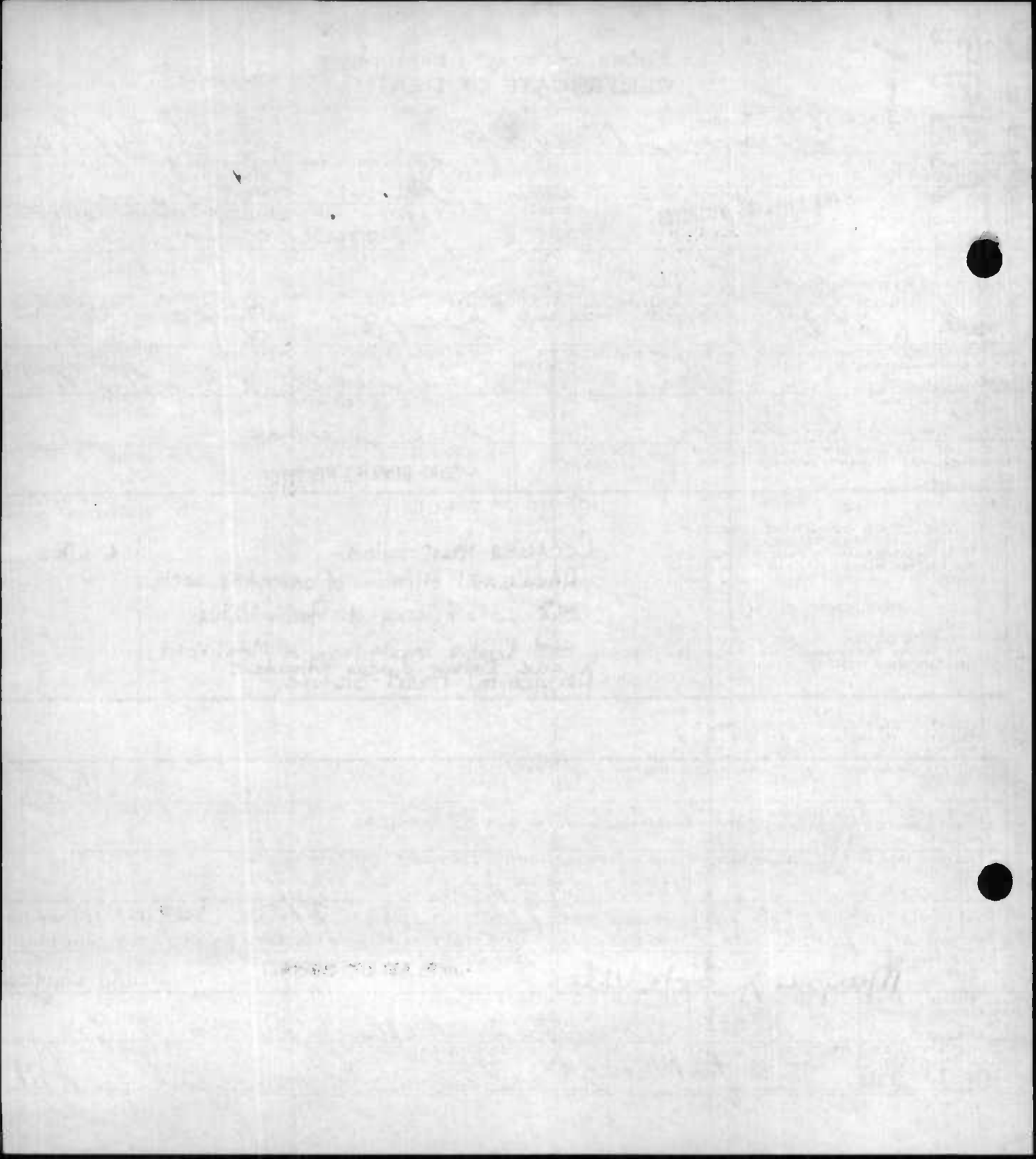
50 6355  
Registered No.

BIRTH NO. 50 6355		1. NAME OF DECEASED (Type or Print) <i>Christine Haislip</i>		2. DATE OF DEATH <i>July 24, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE <i>N. Carolina</i> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Hamilton</i> V-30			
C. Length of stay in Baltimore <i>8 days</i>		D. STREET ADDRESS (If rural, give location)			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <i>2-1-13</i>	9. AGE (In years last birthday) <i>37 2</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Robertsonville N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Groves C. Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Lina James</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>	
				ADDRESS	

18. <i>754.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST.		(A) <i>Coronary Heart Failure</i>		<i>6 wks.</i>	
		DUE TO <i>Anomalous dilatation of ascending aorta with Insufficiency of Aortic Valve</i>			
		(B) <i>and Relative Insufficiency of Mitral Valve and Patent ductus arteriosus.</i>			
		(C) <i>Congenital Heart Disease.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION <i>7/20</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/12</i> 19 <i>50</i> to <i>7/20</i> 19 <i>50</i> , that I last saw the deceased alive on <i>7/20</i> 19 <i>50</i> , and that death occurred at <i>12:45</i> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Marjorie A. Fortz W.D.</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>July 20, 1950</i>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7-22-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Hamilton Hamilton N.C.</i>		24D. LOCATION (City, town, or county) (State) <i>Hamilton N.C.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 21 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Stewart W. Brown</i>		ADDRESS <i>Baltimore Md.</i>	





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

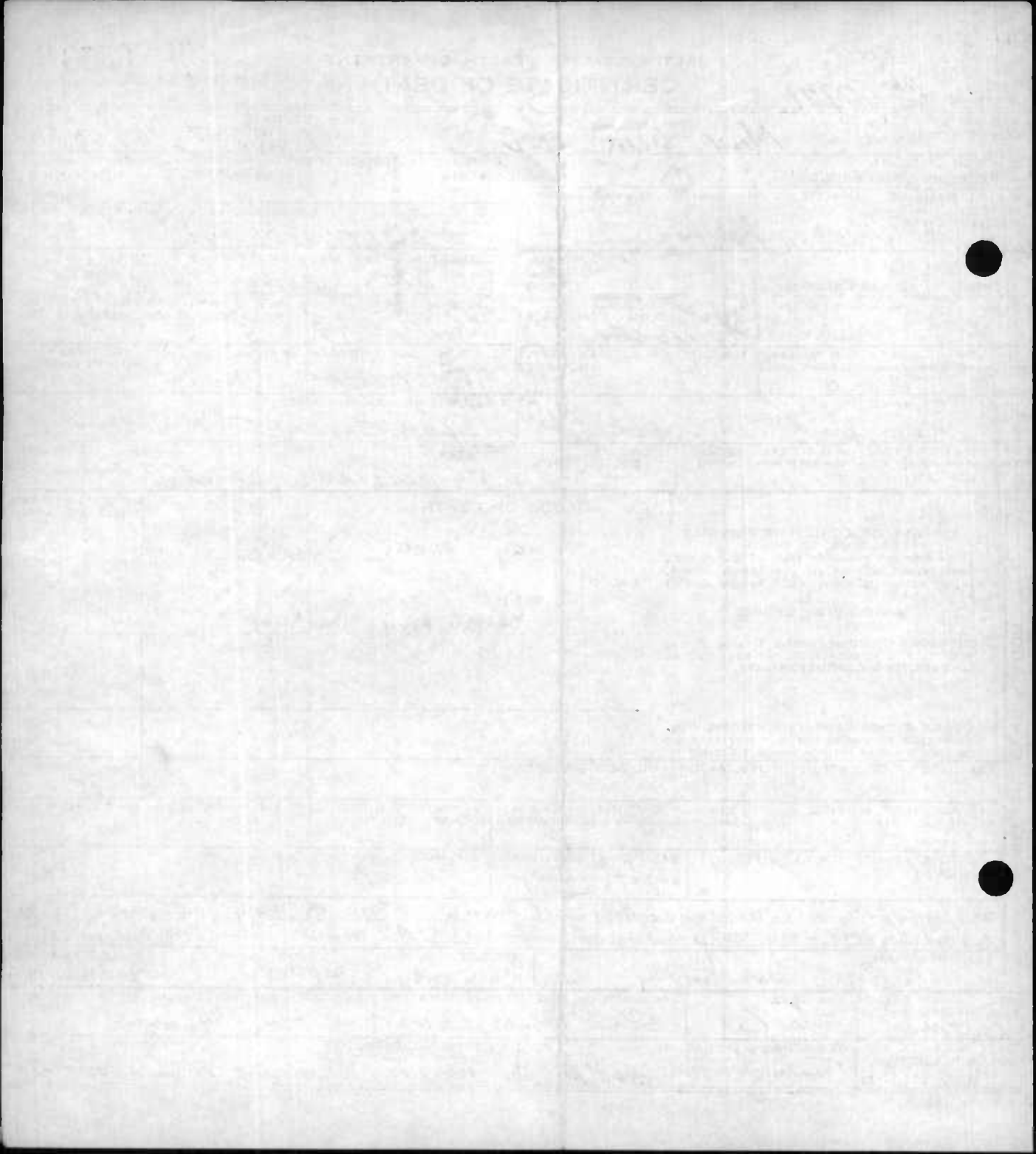
50 6356  
Registered No. \_\_\_\_\_

BIRTH NO. 45 50 6356 21-60941

1. NAME OF DECEASED (Type or Print) <u>MAY SURLAND</u>		2. DATE OF DEATH <u>7/19/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSP.</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>BALTIMORE 25-05</u>	
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <u>3708 PENNINGTON AVE.</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE.</u>	8. DATE OF BIRTH <u>JULY 7, 1945</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>5</u>
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>WILLIAM ORLA SURLAND</u>		14. MOTHER'S MAIDEN NAME <u>ELLA ELIZABETH KAISER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. WILLIAM O. SURLAND</u>		ADDRESS <u>3708 PENNINGTON AVE.</u>	

18. <u>32515</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Tay - Sachs Disease</u>		INTERVAL BETWEEN ONSET AND DEATH
(A) _____ DUE TO		
(B) <u>Respiratory Failure</u> DUE TO		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

19A. DATE OF OPERATION <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11 March</u> , 19 <u>50</u> , to <u>19 July</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>18 July</u> , 19 <u>50</u> , and that death occurred at <u>1:15 A.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Robert M. Hiley</u>		23B. ADDRESS <u>University Hospital</u>		23C. DATE SIGNED <u>19 July 1950</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>7/21/50</u>		24C. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN CEM.</u>	
24D. LOCATION (City, town, or county) <u>PITCHIE HWY</u>		24E. DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 21 1950</u>		24F. REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 21 1950</u>		24H. REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>		25. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>	
24I. ADDRESS <u>715 LIGHT ST - 30</u>		24J. ADDRESS <u>715 LIGHT ST - 30</u>		24K. ADDRESS <u>715 LIGHT ST - 30</u>	



162  
0 6357

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

420.1 50 6357  
Registered No. 50-6357

1. NAME OF DECEASED (Type or Print) <b>Emma Marie Obrecht</b>				2. DATE OF DEATH <b>July 19, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>112 Warren Avenue</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore - Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) <b>112 Warren Avenue</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 28, 1868</b>		9. AGE (In years last birthday) <b>82</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>K. Wm. Schmidt</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>George F. Obrecht, Sr. - 112 Warren Ave</b>		

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial insufficiency</b>		<b>1 day</b>
DUE TO		
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Widespread generalized cerebral, coronary and peripheral vascular sclerosis</b>		<b>10 yrs. +</b>
DUE TO		
(C)		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Sept. - , 19 37** **7-19-**, 19 **50**, that I last saw the deceased alive on **5-26-**, 19 **50**, and that death occurred at **-** m., from the causes and on the date stated above.

23A. SIGNATURE <b>Thomas Count Woff</b> M. D.	23B. ADDRESS <b>11 East Chase Street</b>	23C. DATE SIGNED <b>7-19-50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-22-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Frederick Ave., Balto., Md.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>7-21-50</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>John F. Denny, Inc. - 715 Light Street</b>
--	---	---

MEDICAL CERTIFICATE

10

RECEIVED

NOV 1963

100-44148

11

1. NAME OF DECEASED  
(Type or Print) VARHOLY, LOUIS F.

2. DATE OF DEATH  
19 July 1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland Franklin Sq. Hosp  
B. FULL NAME OF HOSPITAL OR INSTITUTION  
Franklin Square Hospital  
C. Length of stay in Baltimore  
Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE  
Maryland  
B. COUNTY  
Baltimore  
C. CITY OR TOWN  
Baltimore  
D. STREET ADDRESS (If rural, give location)  
1000 Church St.

5. SEX  
M

6. COLOR OR RACE  
White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
MARRIED

8. DATE OF BIRTH  
12-14-97

9. AGE (In years last birthday)  
63

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
PAINTER

10B. KIND OF BUSINESS OR INDUSTRY  
COAST GUARD

11. BIRTHPLACE (State or foreign country)  
Phila.

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME  
Egla2 VARHOLY

14. MOTHER'S MAIDEN NAME  
CATHERINE HANSELY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  
-

16. SOCIAL SECURITY NO.  
213-01-9556

17. INFORMANT  
MRS ANNA J. Varholy

ADDRESS  
1000 Church St.

18. 330.X  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
CAUSE OF DEATH  
(A) SUBARACHNOID HEMORRAGE  
DUE TO CEREBRAL  
(B) ARTERIOSCLEROSIS.  
DUE TO  
(C)  
INTERVAL BETWEEN ONSET AND DEATH  
2 DAYS  
NOT KNOWN

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION  
2

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 July, 1950, to 19 July, 1950 that I last saw the deceased alive on 19 July, 1950, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE  
John W. Demand

23B. ADDRESS  
M. D. Franklin Sq Hosp

23C. DATE SIGNED  
20 July 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)  
Burial

24B. DATE  
7-22-50

24C. NAME OF CEMETERY OR CREMATORY  
Holy Cross

24D. LOCATION (City, town, or county) (State)  
Annapolis Blvd Md

DATE RECEIVED BY LOCAL REGISTRAR  
JUL 21 1950

REGISTRAR'S SIGNATURE  
Wilmington Williams, Md

25. FUNERAL DIRECTOR  
John Flenny Inc

ADDRESS  
715 Light St.

July 20, 1964

Dear Mr. [illegible]

I have just received your letter of July 16, 1964.

I am sorry that I cannot give you a more definite answer.

I am sure that you will understand my position.

I am sure that you will understand my position.

I am sure that you will understand my position.

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I am sure that you will understand my position.

I am sure that you will understand my position.



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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6359  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Julia Ann Brice		June 27, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE Baltimore City Hospitals 4940 Eastern Avenue		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 219 Colvin Street			
5. SEX Female		6. COLOR OR RACE Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH Feb. 18, 1866	
13. FATHER'S NAME Theodore Veasey		14. MOTHER'S MAIDEN NAME Elizabeth Patterson		9. AGE (in years last birthday) 84	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, no or unknown		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY?	
				17. INFORMANT Baltimore City Hospitals Records* 4940 Eastern Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 321X Cerebrovascular Accident		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 24, 1942 to June 27, 1950, that I last saw the deceased alive on June 27, 1950, and that death occurred at 8:00 PM, from the causes and on the date stated above.					
23A. SIGNATURE J. S. Ozyen		23B. ADDRESS 4940 Eastern Avenue		23C. DATE SIGNED June 29, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
				24D. LOCATION (City, town, or county) (State) UNIVERSITY MEDICAL SCHOOL JUL 19 1950	
DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1950		REGISTRAR'S SIGNATURE Wilmington Williams, M.D.		25. FUNERAL DIRECTOR'S ADDRESS Commissioner of Health	

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO : DIRECTOR, FBI  
FROM : SAC, [illegible]  
SUBJECT: [illegible]  
[illegible text follows]

[illegible text follows]

[illegible text follows]



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626  
0 6361

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6361  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>PAUL PARKER</b>			2. DATE OF DEATH <b>July 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>25 yrs</b>			D. STREET ADDRESS (If rural, give location) <b>1401 Winchester Street</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, <u>WIDOWED</u> , DIVORCED (Specify)	8. DATE OF BIRTH <b>4-18-1893</b>		9. AGE (In years last birthday) <b>57</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Apt. houses</b>	11. BIRTHPLACE (State or foreign country) <b>West River, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Issiac Parker</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Carter</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-22-7346</b>	17. INFORMANT ADDRESS <b>Sarah Parker 57 College Ck Trs.</b>		

18. <b>4221</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>	CAUSE OF DEATH <b>Annapolis, Md.</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(A) DUE TO	
	(B) DUE TO	
	(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Stanley K. Dunleavy</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 19, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 21, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Galesville, Galesville, Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		REGISTRAR'S SIGNATURE <i>Washington Williams, Md.</i>		25. FUNERAL DIRECTOR ADDRESS <b>William Reese 108 Wash. St. Annapolis, Md.</b>	





230

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 58 6382

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WILLIAM GUEST

2. DATE  
OF  
DEATH

July 10, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Harbor--East Falls Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

K

D. STREET ADDRESS (If rural, give location)

O NO HOME

C. Length of stay in Baltimore

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

U

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

N

9. AGE (In years  
last birthday)

65?

If Under 1 Year  
Months DaysIf Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

K

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

N

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

N

17. INFORMANT

ADDRESS

18. E929.8

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Drowning

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
PRIMARY OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)  
Found in harbor21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Found in harbor--East Falls Avenue 3/2

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
July 10, 1950 (Found) m.21E. INJURY OCCURRED  
WHILE AT NOT WHILE  
WORK ☐ AT WORK ☒

21F. HOW DID INJURY OCCUR?

Found drowned

22. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.

23A. SIGNATURE

RS Fisher

23B. CHIEF MEDICAL EXAMINER.....☒  
ASSISTANT MEDICAL EXAMINER.....☐  
M.D. MEDICAL INVESTIGATOR.....☐23C. DATE SIGNED  
7-11-5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY, OR PLACE OF INTERMENT (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

The Registrar Williams, M.

25. FUNERAL DIRECTOR

Commissioner of Health

ADDRESS

183

VS 151

N-990X

JOHN HOPKINS MEDICAL SCHOOL JUL 19 1950

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT

May 12, 1950

Patron - Mr. J. H. Brown

Patron

May 12, 1950

May 12, 1950

May 12, 1950

360

6363

BIRTH NO.

6363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

6363

Registered No.

50 6363

1. NAME OF DECEASED (Type or Print)

Anna Marie Rader

2. DATE OF DEATH

7/18/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

STATE Maryland B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION

Maryland General Hospital

6. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 8-06

7. STREET ADDRESS (If rural, give location)

1902 East Federal Street

8. Length of stay in Baltimore

Life

9. SEX

Female

10. COLOR OR RACE

White

11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Married

12. DATE OF BIRTH

3/26/82

13. AGE (In years last birthday)

68

14. BIRTHPLACE (State or foreign country)

Maryland

15. CITIZEN OF WHAT COUNTRY?

U.S.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

17. KIND OF BUSINESS OR INDUSTRY

at home

18. FATHER'S NAME

John H. C. Lassahn

19. MOTHER'S MAIDEN NAME

Catherine Mohr

20. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

21. SOCIAL SECURITY NO.

22. INFORMANT

Mr. George A. Rader

23. ADDRESS

1902 E. Federal Street - 13

24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septic infarcts of left kidney

25. ANTECEDENT CAUSES (DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Septicemia

26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Probably infection from tonsils

27. INTERVAL BETWEEN ONSET AND DEATH

22 days

28. II

Diabetes mellitus

29. INTERVAL BETWEEN ONSET AND DEATH

25 years

30. DATE OF OPERATION

7/21/1950

31. MAJOR FINDINGS OF OPERATION

32. AUTOPSY?

YES ☒ NO ☐

33. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

34. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

35. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

36. 21F. HOW DID INJURY OCCUR?

37. 22. I hereby certify that I attended the deceased from 7/3, 1950, to 7/18, 1950, that I last saw the deceased alive on 7/18, 1950 and that death occurred at 430 P. M., from the causes and on the date stated above.

38. 23A. SIGNATURE

Marguerite Louise Cade

39. 23B. ADDRESS

Maryland General Hospital

40. 23C. DATE SIGNED

7/18/50

41. 24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

42. 24B. DATE

7/21/1950

43. 24C. NAME OF CEMETERY OR CREMATORY

Mount Olivet cemetery

44. 24D. LOCATION (City, town, or county) (State)

Baltimore Md.

45. DATE RECEIVED BY LOCAL REGISTRAR

JUL 21 1950

46. REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

47. ADDRESS

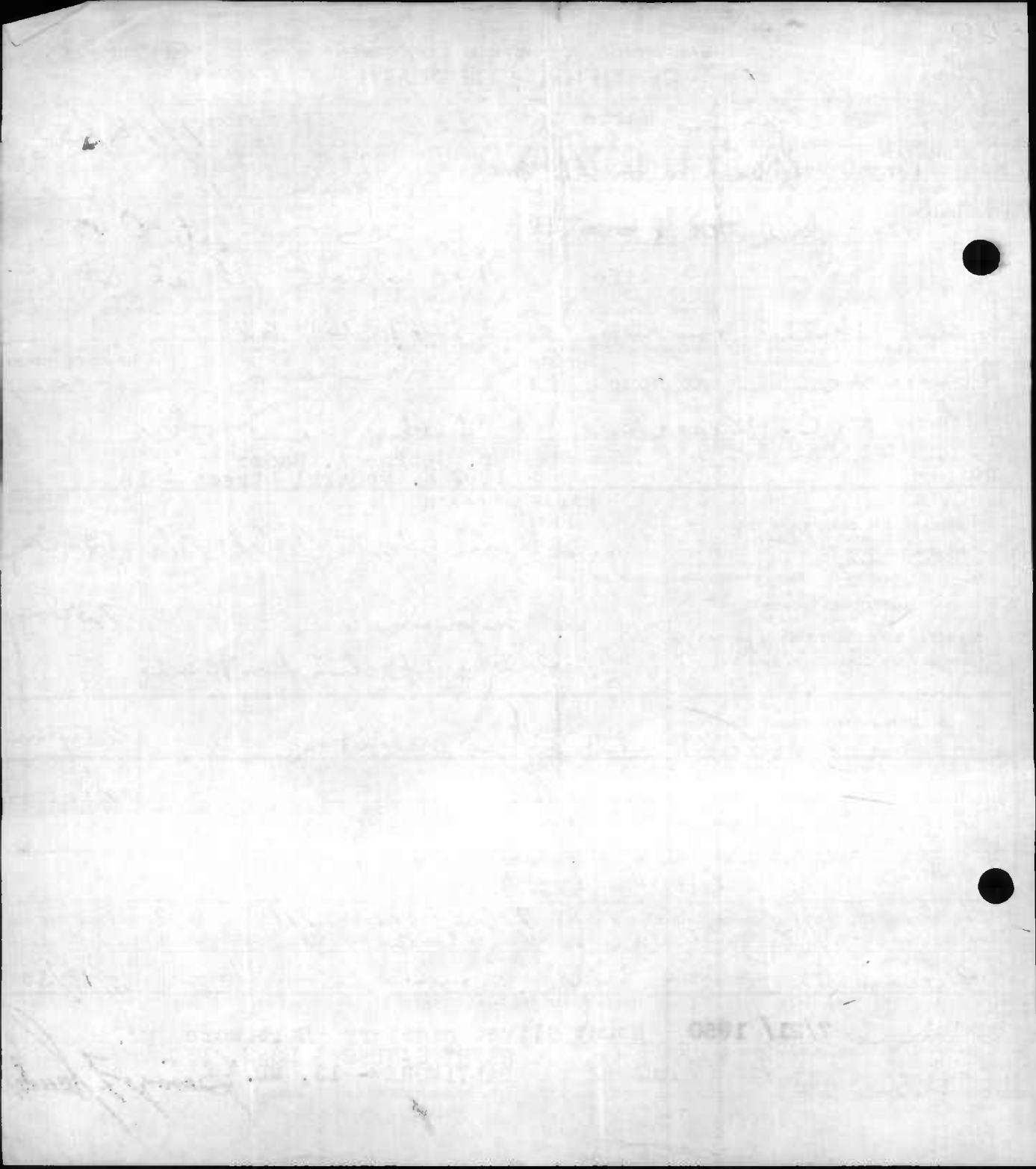
HENRY SANDER & SONS, INC. BALTIMORE - 13, MD.

48. SIGNATURE

George J. Sander

49. VS 150

61



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

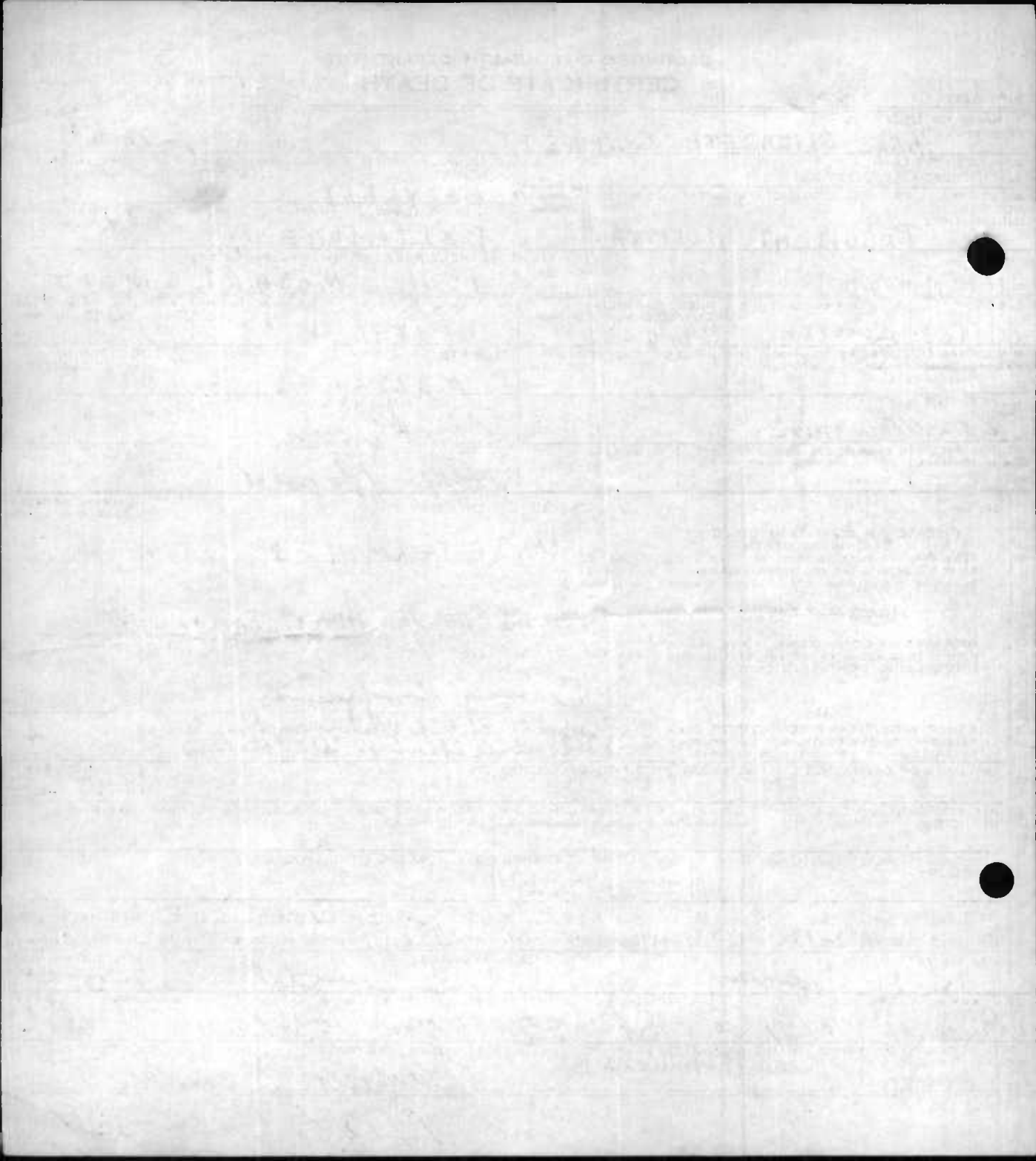
50 6364  
Registered No. \_\_\_\_\_

630  
BIRTH NO. 6364

1. NAME OF DECEASED (Type or Print) <b>ANNE ELIZABETH GARRETT</b>			2. DATE OF DEATH <b>7-13-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY _____		
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>PROVIDENT HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 16-00</b>		
6. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>1511 MOSHER STREET</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>1891</b>		9. AGE (in years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Hosp Record</b>		

18. <b>470.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>UNDETERMINED</b>			INTERVAL BETWEEN ONSET AND DEATH		
DUE TO					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>CONGESTIVE HEART FAILURE</b>			DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Coronary insufficiency Probable Intest. Disturbance due to: @ Mesenteric Thromb. @ Valsalva</b>					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7-12</b> , 19 <b>50</b> , to <b>7-13</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-13</b> , 19 <b>50</b> , and that death occurred at <b>2:45</b> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>J. H. Pathway</b>		23B. ADDRESS M. D. <b>Provident Hospital</b>		23C. DATE SIGNED <b>7-14-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/21/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St Peter Fern</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>	REGISTRAR'S SIGNATURE <b>Amington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Rayner Sanders</b>		ADDRESS <b>1412 E. Preston St</b>	

MEDICAL CERTIFICATION





000

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6365

Registered No.

BIRTH NO. 50 6365

1. NAME OF DECEASED  
(Type or Print)

Anna May

2. DATE OF DEATH

July 20/1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, If institution / residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

58 years

5. SEX

male white

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

6-29-80

9. AGE (in years last birthday)

70

10. Under 1 Year Months: Days

0 21

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, also if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Emil Shutter

Germany

14. MOTHER'S MAIDEN NAME

Cmelia Shutter

Germany

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHNS HOPKINS HOSPITAL

ADDRESS

18. 470.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

Myocardial infarction

3 wks.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO  
(C)

Arteriosclerotic heart disease

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/13 to 7/20, 1950, that I last saw the deceased alive on 7/20, 1950, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Joseph Stokes III

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 21 1950

Wilmington Williams, M.D.

Albert L. Hilly

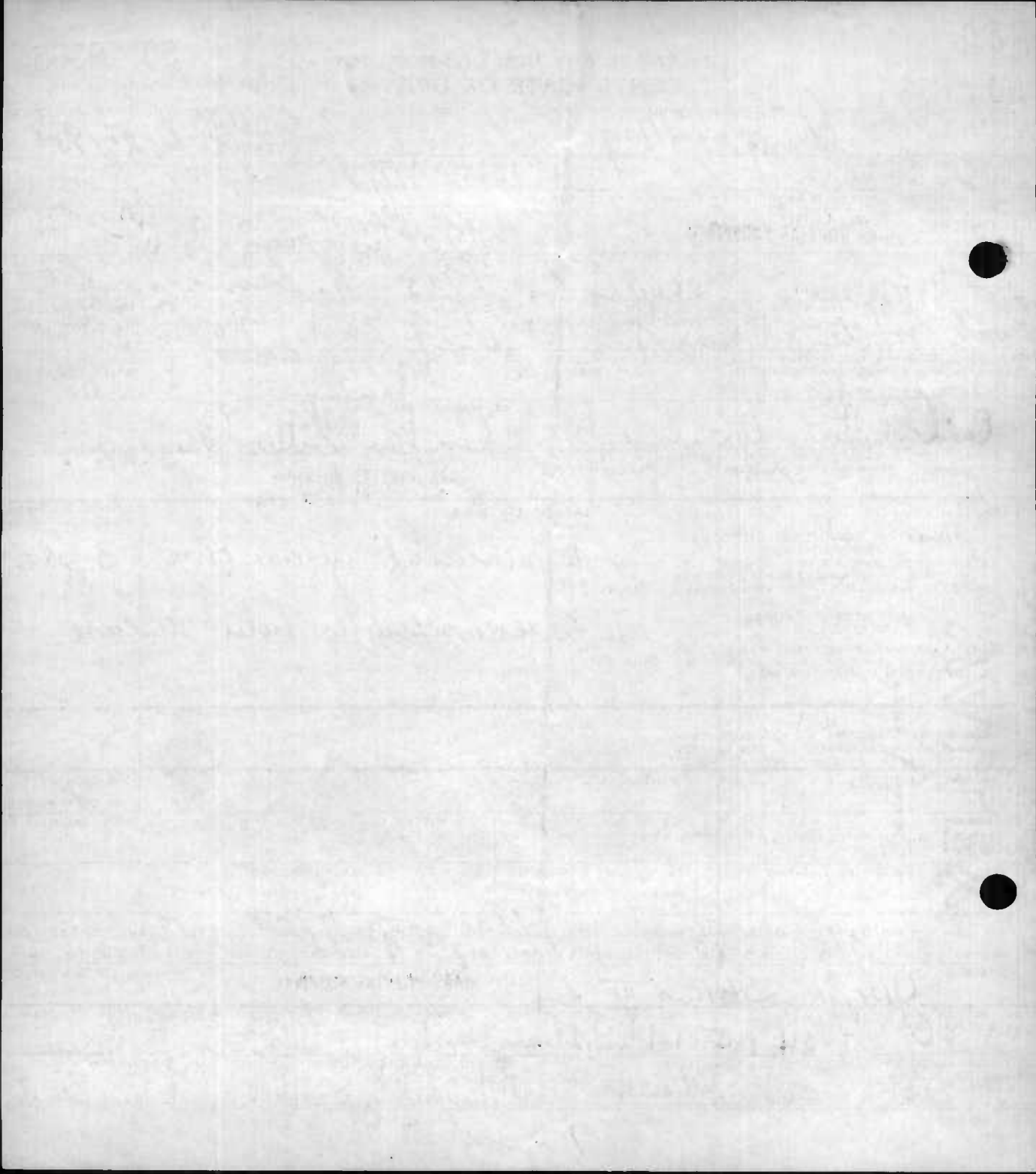
1606 1/2 Chester Street

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7208A

937

MEDICAL CERTIFICATION



656

6366

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6366

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE B. COUNTY before admission)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

8. DATE OF BIRTH

9. AGE (In years last birthday) If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A)

Cardiovascular Disease

10 years

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

Hypertension, vascular

8 years

DUE TO

(C)

Arteriosclerosis, generalized

6 years

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 13 March 50 to 17 July 50, that I last saw the deceased alive on 17 July 1950, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, OR REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

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 12th of November 1900

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6367  
Registered No. \_\_\_\_\_

645  
6367  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <u>Ida Berlin</u>		2. DATE OF DEATH <u>7/20/50</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		C. CITY OR TOWN (If outside corporate limits, write FULL and give township) <u>Baltimore</u> <u>15-04</u>	
C. Length of stay in Baltimore <u>50</u> Yrs. <u>50</u> Mos. <u>50</u> Days		D. STREET ADDRESS (If rural, give location) <u>2008 N. Bontaloe St</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>66</u>
13. FATHER'S NAME <u>Isaac</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		12. CITIZEN OF WHAT COUNTRY? _____	
16. SOCIAL SECURITY NO. _____		14. MOTHER'S MAIDEN NAME <u>Etta</u>	
17. INFORMANT <u>Kalman Berlin</u>		ADDRESS <u>Same</u>	

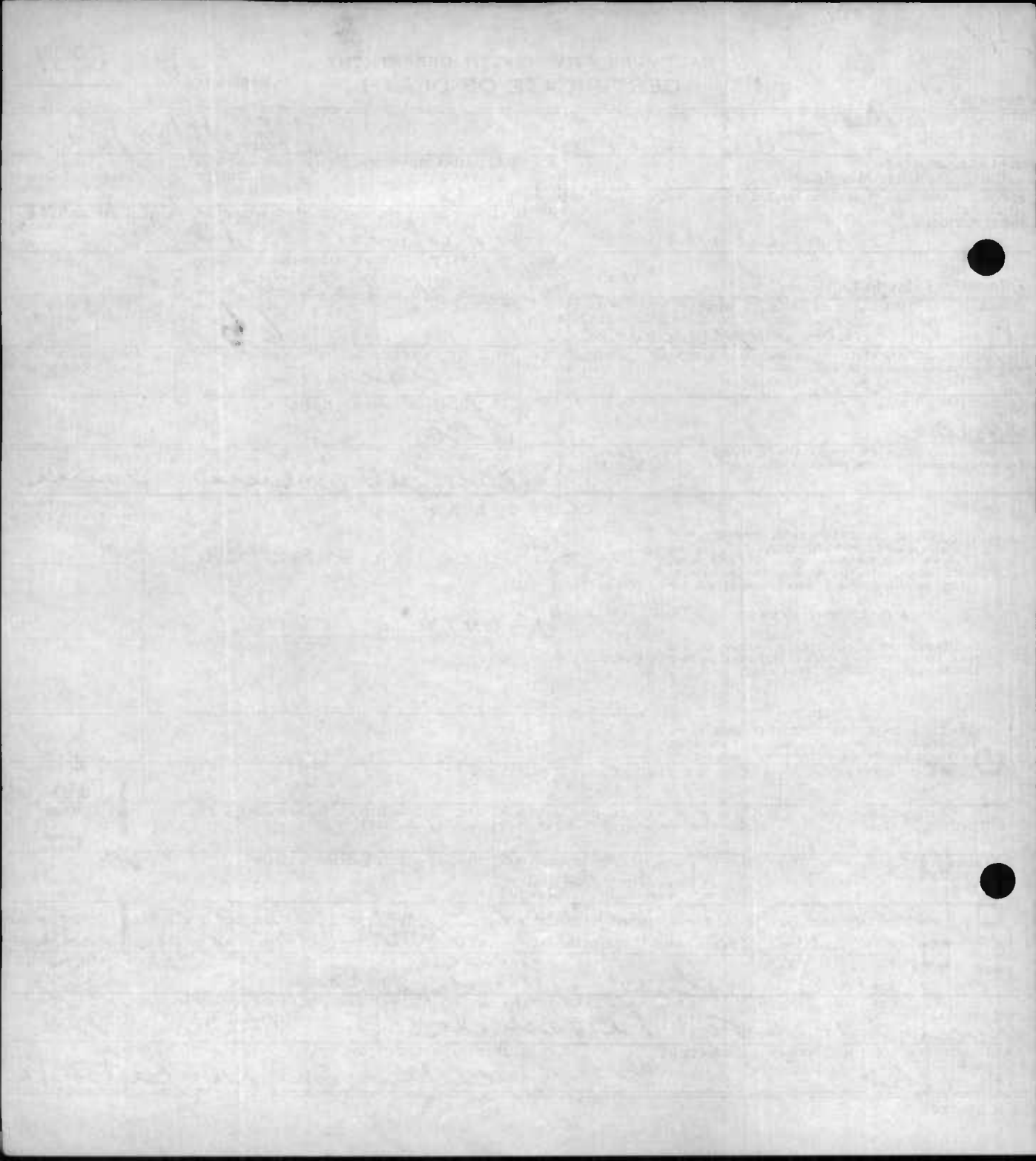
18. <u>420.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Myocardial infarction</u> DUE TO (A) _____  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>ASCYD</u> DUE TO (B) _____  (C) _____	INTERVAL BETWEEN ONSET AND DEATH _____ _____ _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____ _____ _____	

19A. DATE OF OPERATION <u>7/20/50</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7/14, 1950, to 7/20, 1950, that I last saw the deceased alive on 7/20, 1950, and that death occurred at 3:00 m., from the causes and on the date stated above.

23A. SIGNATURE <u>Jerome J. Collier</u> M. D.	23B. ADDRESS <u>Sinai Hospital</u>	23C. DATE SIGNED <u>7/20/50</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7-21-50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>
24D. LOCATION (City, town, or county) <u>Balto Md</u>		24E. STATE <u>Md</u>

DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1950 REGISTRAR'S SIGNATURE Huntington Williams, M.D. 25. FUNERAL DIRECTOR Jack Lewis ADDRESS 2100 Canton Pl





636

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

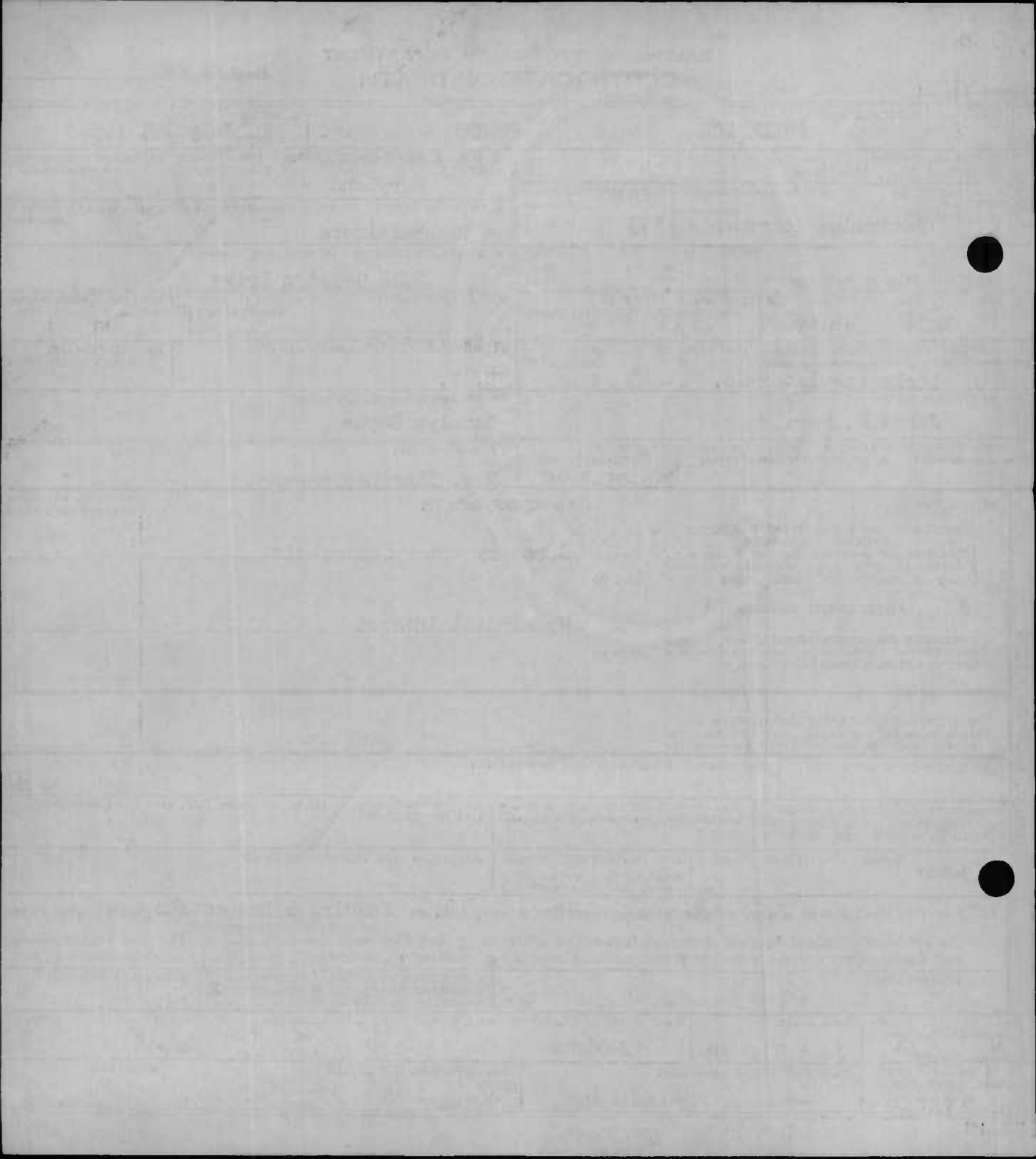
Registered No. 50 6368

BIRTH NO. 6368

1. NAME OF DECEASED (Type or Print) <b>FREDERICK W. PORTER</b>		2. DATE OF DEATH <b>July 19, 1950</b>	
3. PLACE OF DEATH: a. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Pentridge Apartments #273</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>24</b> Yrs. Mos. Days		d. STREET ADDRESS (If rural, give location) <b>3912 Gelston Drive</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>	8. DATE OF BIRTH <b>Mar. 7, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locke Insulator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Co. Time &amp; Study</b>	
13. FATHER'S NAME <b>James M. Porter</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn Boyce</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. <b>216-05-3475</b>	
17. INFORMANT <b>Mrs. Florence Porter</b>		ADDRESS	

18. <b>470 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery sclerosis</b> DUE TO <b>Myocardial infarct</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <b>Myocardial infarct</b> (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <b>Inquiry &amp; Inspection</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>Stanley H. Durlacher</b>		23b. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input type="checkbox"/>		23c. DATE SIGNED <b>July 20, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 22, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Western</b>	
24d. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>Harry H. McPherson</b>		ADDRESS <b>4101 Edmonson</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		REGISTRAR'S SIGNATURE <b>Christington Williams, M.D.</b>		94a ✓	



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6369**

**67-3**  
**50 6369**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>PAULINE C. HERGET.</b>		2. DATE OF DEATH <b>JULY 20 1950.</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland <b>BALTIMORE CITY.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTIMORE CITY.</b> B. COUNTY			
b. FULL NAME OF (If not in hospital or institution, give street address or location) <b>4700 HARFORD AVE</b> INSTITUTION <b>HARFORD CONVALESCENCE HOME.</b>		c. CITY OR TOWN (If outside corporate limits, with RURAL and give township) <b>BALTIMORE CITY.</b> <b>14-01</b>			
c. Length of stay in Baltimore <b>LIFE</b>		d. STREET ADDRESS (If rural, give location) <b>1427 JOHN STREET.</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>Nov 16, 1880</b>		9. AGE (In years last birthday) <b>69</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto.</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>JAMES M. COATES</b>			
14. MOTHER'S MAIDEN NAME <b>LAURA JANE CAMPBELL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>CHAS HERGET 4317 MARBLE HALL RD</b>			
18. <b>422.1</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC MYOCARDITIS. FEBRUARY 2 1950.</b>					
DUE TO (A)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE. (A) STATING THE UNDERLYING CONDITION LAST. <b>ARTERIOR SCLEROSIS. 1950.</b>					
DUE TO (B)					
<b>CHRONIC ARTHRITIS. DEFORMAN. 1945.</b>					
DUE TO (C)					
<b>KERATOSIS. 1945.</b>					
19a. DATE OF OPERATION <b>NONE.</b>		19b. MAJOR FINDINGS OF OPERATION <b>NONE</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>FEBRUARY 2 1950</b> , to <b>JULY 20 1950</b> , that I last saw the deceased alive on <b>JULY 20 1950</b> , and that death occurred at <b>1.45P</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>Chas J. Clautier</b>		23b. ADDRESS <b>3013 ST PAUL STREET.</b>		23c. DATE SIGNED <b>JULY 20 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>7/21/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEM</b>	
24d. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>		24e. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		24f. REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
24g. VS 150		25. FUNERAL DIRECTOR <b>Charles H. Enawickan</b>		25b. ADDRESS <b>118 W. Mt. Royal Ave. 93c</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

3

REPORTED BY

DATE OF REPORT

REPORTED BY

DATE OF REPORT

REPORTED BY

DATE OF REPORT

320

6370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 6370

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

MRS ALTA JUDIK

7-19-1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

ST. AGNES HOSPITAL

Female

white

married

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

9. AGE (in years last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Upperco - P.O. Md.

Dover Road

44

Housewife

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

N.Y.

U.S.A.

CHARLES MC FARLAND

NELLIE FLECK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. 134.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Acute Pulmonary Edema

(B) Cardiac Failure

(C) Blastomycosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1950, to 7/19, 1950 that I last saw the deceased alive on 7/19, 1950, and that death occurred at 4:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 22 1950

Druid Ridge

Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS

UL 21-1950

Huntington Williams, M.D.

Henry W. Jenkins & Sons Co 4905 York Rd

VS 150

43

320

6370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

50 6370

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

MRS ALTA JUDIK

7-19-1950

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

B. FULL NAME OF HOSPITAL OR INSTITUTION

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

ST. AGNES HOSPITAL

Female

white

married

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

9. AGE (in years last birthday)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Upperco - P.O. Md.

Dover Road

44

Housewife

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

N.Y.

U.S.A.

CHARLES MC FARLAND

NELLIE FLECK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. 134.0

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Acute Pulmonary Edema

(B) Cardiac Failure

(C) Blastomycosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/19, 1950, to 7/19, 1950 that I last saw the deceased alive on 7/19, 1950, and that death occurred at 4:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

July 22 1950

Druid Ridge

Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS

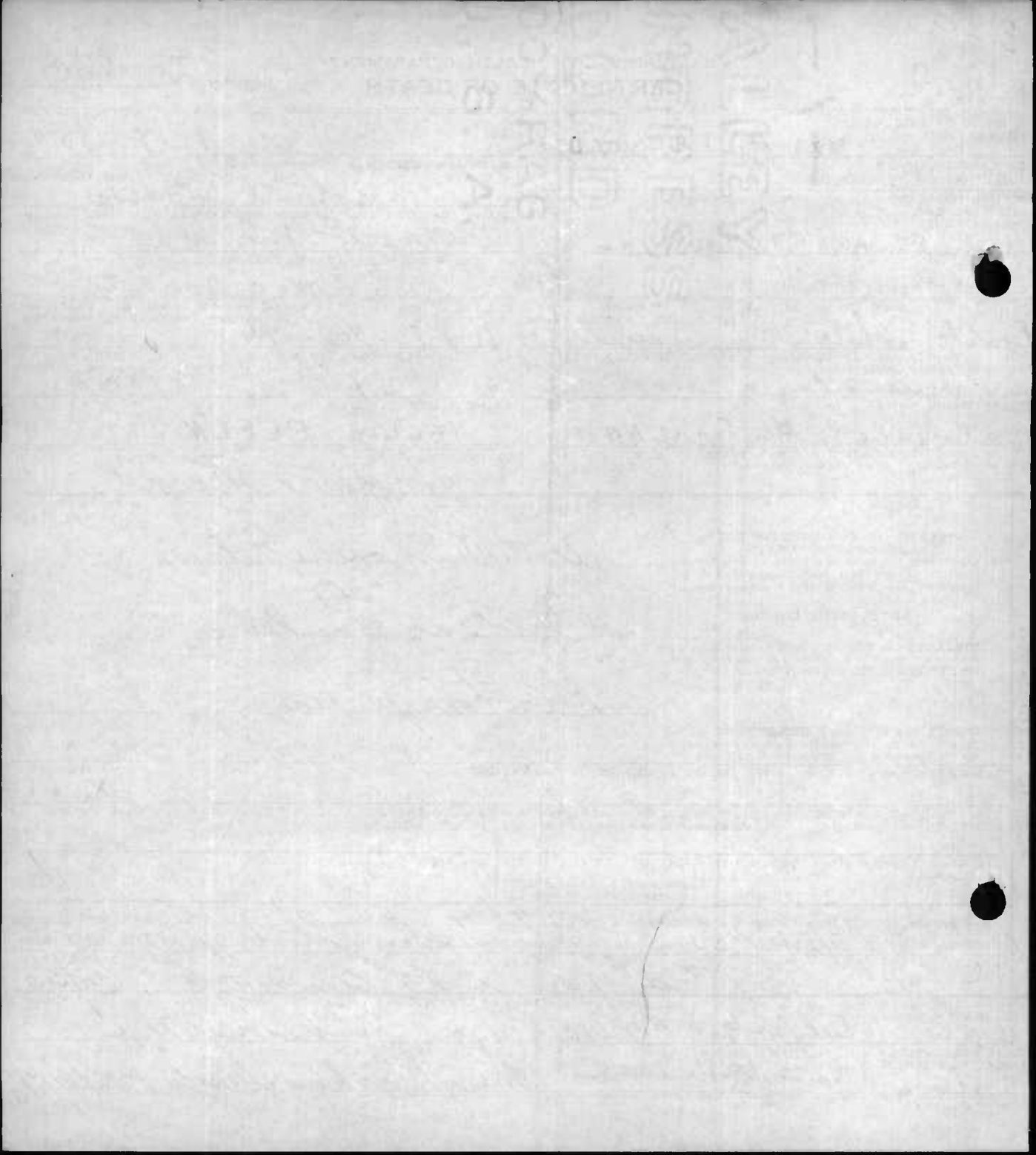
UL 21-1950

Huntington Williams, M.D.

Henry W. Jenkins & Sons Co 4905 York Rd

VS 150

43





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6371

Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>WARREN M. DRIVER, Sr.</b>		2. DATE OF DEATH <b>July 20, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>336 Rosebank Ave.</b>		C. CITY OR TOWN (If outside corporate limits, give township) <b>Baltimore</b>			
C. Month of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>336 Rosebank Ave.</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>May 22, 1873</b>	9. AGE (In years; last birthday) <b>77</b>	10. Under 1 Year: Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman (retd)</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Driver</b>			12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>212-01-8059</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			17. INFORMANT ADDRESS <b>Mrs. Nellie B. Driver 336 Rosebank Ave.</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Arteriosclerotic C-V-D</b> DUE TO <b>(C)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>2</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>---</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>		
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>---</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>---</b>		

I hereby certify that I attended the deceased from **July 20, 1950**, to **July 20, 1950**, that I last saw the deceased alive on **July 20, 1950**, and that death occurred at **5:50 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Arthur M. Reed</b>	23B. ADDRESS M. D. <b>8 Longwood Road</b>	23C. DATE SIGNED <b>July 21, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/22/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Govans Presby. Cem.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>	REGISTRAR'S SIGNATURE <b>Wm. J. Zickner &amp; Sons, Balto Md.</b>	24D. LOCATION (City, town, or county) (State) <b>Govans, Md.</b>

2

10-10

10-10



453  
50 6372  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6372  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MRS. ELIZABETH WIELAND</b>		2. DATE OF DEATH <b>JULY 20, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Balto</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>4221 Kolb Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto - Md 26</b>	
6. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>4221 Kolb Ave</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>11-22-87</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>62</b>
13. FATHER'S NAME <b>Pat. Fooks</b>		11. BIRTHPLACE (State or foreign country) <b>Balto</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Catherine Ritter</b>	
17. INFORMANT <b>August Wieland</b>		ADDRESS <b>Same</b>	

18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Cerebral Hemorrhage</b> DUE TO (B) <b>Cardio-Vascular Hypertensive Disease</b> DUE TO (C) <b>Atherosclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b> <b>3 years.</b> <b>3 years.</b>
--	---	--

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
I hereby certify that I attended the deceased from <b>July 14</b> , 19 <b>50</b> , to <b>July 20</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 20</b> , 19 <b>50</b> , and that death occurred at <b>4:20 P.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Michael J. Dausch</b>		23B. ADDRESS <b>4636 Belvoir Road</b>		23C. DATE SIGNED <b>7/20/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Schwartz</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. LOCATION (State) <b>Md</b>		24F. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>	
REGISTRAR'S SIGNATURE <b>William M. Williams</b>		25. FUNERAL DIRECTOR <b>Lily's Zehn</b>		ADDRESS <b>400 S. Wofford</b>	

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6373

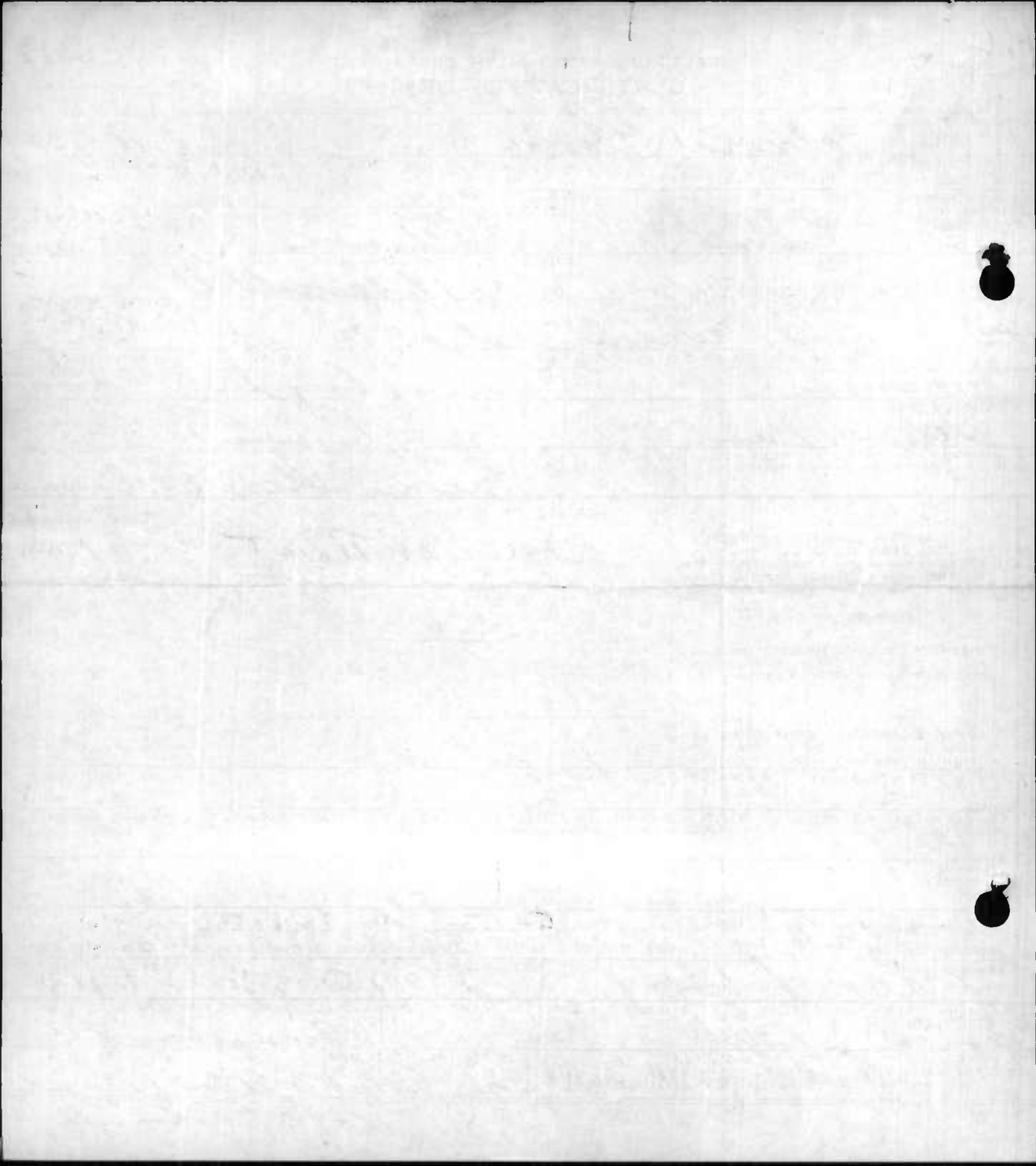
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>Elnora Glover</i>		2. DATE OF DEATH <i>July 18, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>12-05</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>327 E. Lanvale St.</i>		C. CITY OR TOWN (If outside corporate limits, with RURAL and give township) <i>Baltimore</i>	
C. Length of stay in Baltimore <i>5 1/2 yrs.</i>		D. STREET ADDRESS (If rural, give location) <i>327 E. Lanvale St.</i>	
5. SEX <i>7.</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>July 10 1881</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>69</i>
13. FATHER'S NAME <i>Alfred Cain</i>		11. BIRTHPLACE (State or foreign country) <i>Orangeburg S. C.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <i>Mary Lurenia ?</i>	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
17. INFORMANT <i>Freddie Glover</i>		ADDRESS <i>327 E. Lanvale</i>	

18. <i>148X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  CAUSE OF DEATH <i>CANCER OF THROAT</i> (A) DUE TO  (B) DUE TO  (C) DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>9 MONTHS</i>
<p>II</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from <i>5-15-50</i>, to <i>7-18-50</i>, 19<i>50</i>, that I last saw the deceased alive on <i>7-18-50</i>, 19<i>50</i>, and that death occurred at <i>8:15 P.m.</i>, from the causes and on the date stated above.</p>					
23A. SIGNATURE <i>Maxwell L. Adams</i> M. D.		23B. ADDRESS <i>238 N. Cory St</i>		23C. DATE SIGNED <i>7-21-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>July 21/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Orangeburg S. C.</i>	
24D. LOCATION (City, town, or county) (State) <i>Orangeburg S. C.</i>		25. FUNERAL DIRECTOR <i>Mrs. Robert G. Elliott &amp; Daughters</i>		ADDRESS <i>429 N. Caroline St.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 21 1950</i>		REGISTRAR'S SIGNATURE <i>Wilmington Williams, M.D.</i>			

MEDICAL CERTIFICATION





326  
6374BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6374

1. NAME OF DECEASED (Type or Print) <b>Walter S. Hatcher</b>		2. DATE OF DEATH <b>July 19, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1605 Balmor Ct.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>N.J.</b> B. COUNTY <b>Jersey City</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Jersey City</b>	
6. LENGTH OF STAY IN BALTIMORE <b>7 days</b>		D. STREET ADDRESS (If rural, give location) <b>88 A. Clinton Ave</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 10, 1887</b>
9. AGE (In years, last birthday) <b>63</b>		10. UNDER 1 YEAR: Months: Days	
11. UNDER 24 HOURS: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Contracting</b>	
13. FATHER'S NAME <b>James Hatcher</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>James Hatcher</b>		ADDRESS <b>1605 Balmor Ct</b>	

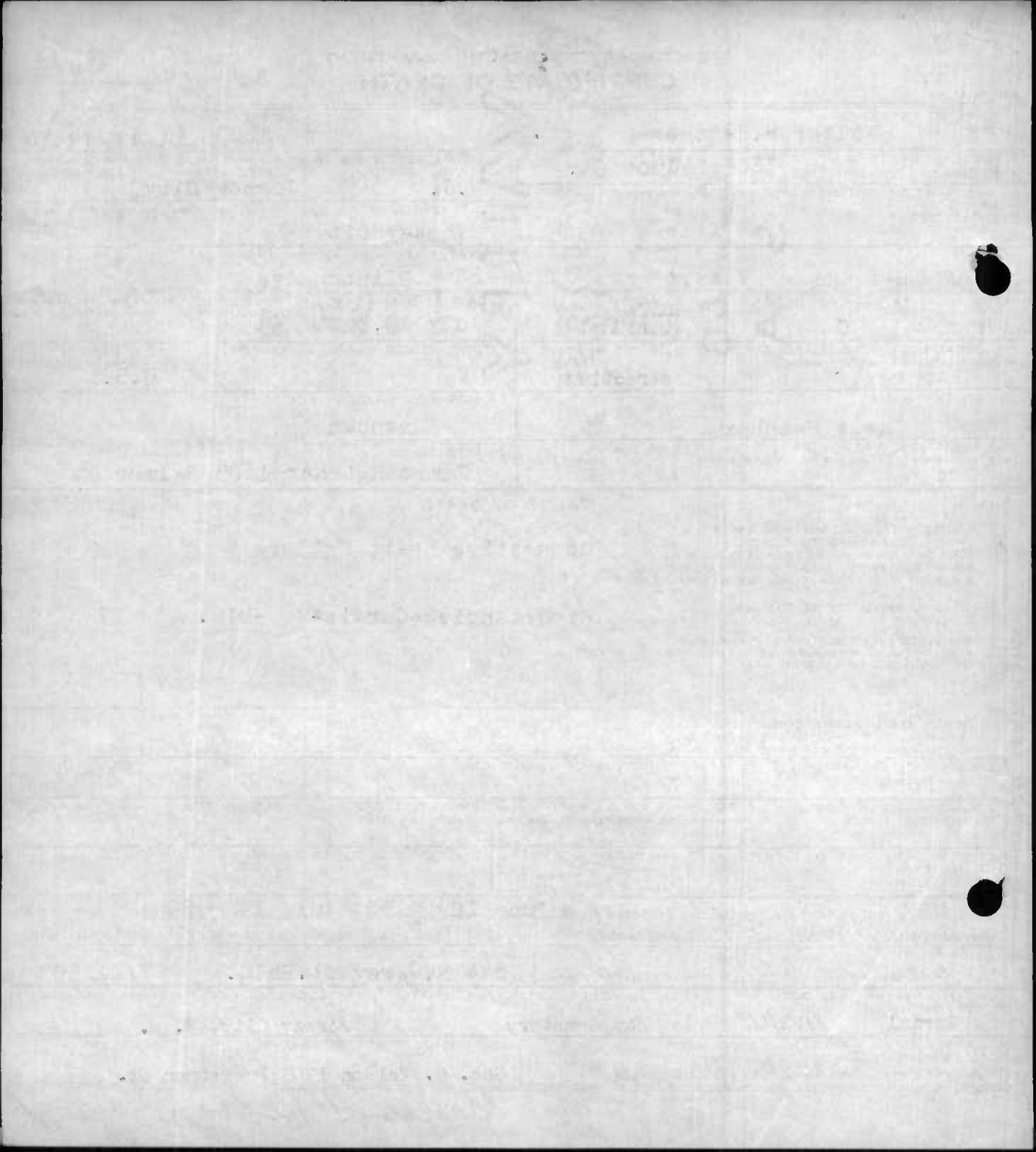
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Congestive Heart Failure</b> DUE TO <b>(B) Hypertensive-Cardio#Vas-Dis.</b> DUE TO <b>(C)</b>	INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>None</b>	19B. MAJOR FINDINGS OF OPERATION <b>X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>X</b>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
I hereby certify that I attended the deceased from <b>June 12, 1950</b> to <b>July 19, 1950</b> , that I last saw the deceased alive on <b>July 19, 1950</b> , and that death occurred at <b>6 P. m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>George McDonald</b> M. D.	23B. ADDRESS <b>844 N. Carey St. Balt.</b>	23C. DATE SIGNED <b>7/21/50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/22/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Bay Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Jersey City, N. J.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Geo. G. Kelson</b>	ADDRESS <b>1303 Presstman St.</b>

970 24

George G. Kelson 937



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6375**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>MARY BUSSELLS</b>			2. DATE OF DEATH <b>July 18, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-08</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore <b>26</b>			D. STREET ADDRESS (If rural, give location) <b>1010 Woodington Road</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>6-23-1924</b>		9. AGE (In years last birthday) <b>26</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ALEXANDER KLEWICKI</b>			14. MOTHER'S MAIDEN NAME <b>MARY LEWANDOWSKI</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.			
			17. INFORMANT ADDRESS <b>MARY KLEWICKI 1443 HULL ST</b>		

18. <b>E871.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Barbiturate Intoxication</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b> DUE TO		
<b>(C)</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>1010 Woodington Road 16/8</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 18, 1950 9.00p m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Accidental ingestion of barbiturates</b>	
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <b>William V. L... ..</b>		23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 19, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-22-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Catholic</b>	
24D. LOCATION (City, town, or county) (State) <b>Old Frederick Rd.</b>		24E. FUNERAL DIRECTOR <b>Charles F. Hill</b>		24F. ADDRESS <b>1501 E. Ford St.</b>	

DATE RECEIVED BY LOCAL REGISTRAR **JUL 21 1950**  
REGISTRAR'S SIGNATURE **Thurston Williams, M.D.**  
V S 151 **N-971.0** **17912**

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Race		5. Date of birth		6. Date of death		7. Place of death		8. Cause of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		White		Jan 1, 1920		Jan 15, 1965		Home		Heart Disease		Dr. J. Smith		Mr. J. Doe	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Usual place of death		17. Usual place of burial		18. Usual place of interment		19. Usual place of cremation		20. Usual place of entombment	
Teacher		High School		Married		123 Main St		ABC Corp		Home		Catholic Church		Catholic Church		Catholic Church		Catholic Church	
21. Usual place of death		22. Usual place of burial		23. Usual place of interment		24. Usual place of cremation		25. Usual place of entombment		26. Usual place of death		27. Usual place of burial		28. Usual place of interment		29. Usual place of cremation		30. Usual place of entombment	
Home		Catholic Church		Catholic Church		Catholic Church		Catholic Church		Home		Catholic Church		Catholic Church		Catholic Church		Catholic Church	
31. Usual place of death		32. Usual place of burial		33. Usual place of interment		34. Usual place of cremation		35. Usual place of entombment		36. Usual place of death		37. Usual place of burial		38. Usual place of interment		39. Usual place of cremation		40. Usual place of entombment	
Home		Catholic Church		Catholic Church		Catholic Church		Catholic Church		Home		Catholic Church		Catholic Church		Catholic Church		Catholic Church	

520

0 637650-14600

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6376

1. NAME OF DECEASED (Type or Print) <b>BOY BOY AMOS</b>		2. DATE OF DEATH <b>7-20-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md. —</b> B. COUNTY <b>BAITO.</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>RURAL</b>	
D. STREET ADDRESS (If rural, give location) <b>Beltsville P.O. 5200</b>			
c. Length of stay in Baltimore <b>1 1/2</b> Days			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <b>LEONARD AMOS</b>		14. MOTHER'S MAIDEN NAME <b>RUTH PYLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HOSP. RECORDS</b>		ADDRESS	
18. <b>773.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Pneumatury</b>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-19-50</b> , 19__ to <b>7-20-50</b> , 19__, that I last saw the deceased alive on <b>7-20-50</b> , and that death occurred at <b>11:45 P.m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Leslie A. Walker</b>		23B. ADDRESS <b>Md. Gen Hosp. City</b>	
23C. DATE SIGNED <b>7/21/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <b>July 22-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Wisebrun</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, Md</b>	
25. FUNERAL DIRECTOR <b>Howard S. Markline</b>		ADDRESS <b>Whale Thaw. Inc</b>	





D-263  
50 6377BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

X 50 6377

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Dougherty		2. DATE OF DEATH July 19, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland U.S. Marine Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pennsylvania B. COUNTY V-35	
B. FULL NAME OF HOSPITAL OR INSTITUTION U.S. Marine Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Philadelphia	
c. Length of stay in Baltimore 162 days		D. STREET ADDRESS (If rural, give location) 1848 Clearfield Street	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single Married	8. DATE OF BIRTH Dec. 13, 1885
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Seafarer	9. AGE (In years last birthday) 64
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Dougherty		14. MOTHER'S MAIDEN NAME Mary Ann Deley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 153-01-0163	
17. INFORMANT Records, US Marine Hospital, Baltimore, Md.		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH Pneumonia, acute, left Empyema, subacute, right glomerulonephritis, chronic E uremia and cardiac hypertrophy with failure	INTERVAL BETWEEN ONSET AND DEATH 2 wks 6 wks
---	--	--

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 7, 1950, to July 19, 1950, that I last saw the deceased alive on 7/19, 1950, and that death occurred at 9:35 am., from the causes and on the date stated above.					
23A. SIGNATURE J. M. D. O. O. I. D.		23B. ADDRESS U.S. Marine Hospital, Balto., Md.		23C. DATE SIGNED	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/24/50		24C. NAME OF CEMETERY OR CREMATORY St. Micheal Cem.	
24D. LOCATION (City, town, or county) Chester		24E. LOCATION (City, town, or county) Pa.		24F. LOCATION (City, town, or county) Pa.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 24 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR John A. Moran	
ADDRESS 3000 E. Balto. St.		ADDRESS		ADDRESS	

STATE OF CALIFORNIA  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Date of Death: \_\_\_\_\_

6. Place of Death: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Signature of Physician: \_\_\_\_\_

9. Signature of Registrar: \_\_\_\_\_

10. Date of Filing: \_\_\_\_\_

L-650  
50 6378

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6378  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH LARNEY</b>		2. DATE OF DEATH <b>4/20/50.</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore.</b>			
c. Length of stay in Baltimore <b>38 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>718 S. Decker Ave. 1-01</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married.</b>	8. DATE OF BIRTH <b>Oct. 26. 1888</b>	9. AGE (In years last birthday) <b>62 yrs</b>	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manufacturer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Icecream (M)</b>		11. BIRTHPLACE (State or foreign country) <b>Rhode Island.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Steven Larney.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rogers.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <b>217-03-8410</b>		17. INFORMANT ADDRESS <b>Mary A. Larney 718 S. Decker Ave.</b>	

18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of liver.</b>	CAUSE OF DEATH (A) ..... DUE TO (B) ..... DUE TO (C) .....	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/31/50</b> , 19 <b>50</b> , to <b>7/20/</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>4-20</b> , 19 <b>50</b> , and that death occurred at <b>3:40pm</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Edith Moore M.D.</b>		23B. ADDRESS <b>Church Home &amp; Hospital</b>		23C. DATE SIGNED	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/25/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>21 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams, Jr.</b>	25. FUNERAL DIRECTOR ADDRESS <b>John A. Moran 3000 E. Balto. St.</b>

55441

124B

STATEMENT OF DEATH

STATE OF NEW YORK

County of \_\_\_\_\_

City of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_

at \_\_\_\_\_

I, \_\_\_\_\_

do hereby certify that \_\_\_\_\_

was born on \_\_\_\_\_

at \_\_\_\_\_

and died on \_\_\_\_\_

at \_\_\_\_\_

from \_\_\_\_\_

caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

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and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

and the death was caused by \_\_\_\_\_

5-412

50 6379

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6379

BIRTH NO. 50-06417

1. NAME OF DECEASED  
(Type or Print)

Silbaugh Hope Elaine

2. DATE  
OF  
DEATH

7-19-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Doctors Hospital

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Doctors Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

X before admission

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 26-34D. STREET ADDRESS (If rural, give location)  
1125 Bunbury Way.

c. Length of stay in Baltimore

114 days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Infant

8. DATE OF BIRTH

March 27, 1950

9. AGE (In years last birthday)

If Under 1 Year Months: Days  
3 20  
If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter Silbaugh L

14. MOTHER'S MAIDEN NAME

Violet Butts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Violet Silbaugh B. 1125 Bunbury Way

18. 756.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO

II Abnormality of Esophagus  
(Congenital)  
I Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ ☒ ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6.5, 1950, to 7.19, 1950 that I last saw the deceased alive on 7/19, 1950, and that death occurred at 7 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Roni G. Glass MD

M. D.

23B. ADDRESS

2224 n Charles St

23C. DATE SIGNED

7.20.1950.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7-21-50

24C. NAME OF CEMETERY OR CREMATORY

Baltimore Cem.

24D. LOCATION (City, town, or county)

Baltimore

(State)

1950

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

George A. Foley Funeral Home - Fayette St.

VS 150

1578

MEDICAL CERTIFICATION





W-452  
50 6380BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6380  
Registered No.

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) <i>Joseph Williams</i>	
2. DATE OF DEATH <i>7-20-50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. City Md.</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>So. Balto. Gen. Hosp.</i>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Baltimore City Md.</i> B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>809 Engine Ct. Baltimore Md.</i> D. STREET ADDRESS (If rural, give location) <i>Oct 14 1875 25-04</i>	
c. Length of stay in Baltimore <i>Life</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed.</i>	8. DATE OF BIRTH <i>Oct. 14-1875</i>
9. AGE (In years last birthday) <i>74</i>	10. UNDER 1 Year Months Days
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Williams</i>	
14. MOTHER'S MAIDEN NAME <i>—</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS <i>Charles Williams 809 Engine Ct.</i>	
18. <i>157 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>CARCINOMATOSIS, SIGNUM CORON; OMENTUM &amp; LIVER</i> DUE TO (B) <i>Carcinoma of body of pancreas</i> DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH <i>(m)</i>	
19. DATE OF OPERATION <i>7</i>	
19A. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. ACCIDENT, SUICIDE, HOMICIDE (Specify)	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.	
23A. SIGNATURE <i>Collicie</i>	
23B. ADDRESS <i>So. General Hosp.</i>	
23C. DATE SIGNED <i>7-21-1950</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
24B. DATE <i>7-24-1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Cathedral</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR	
REGISTRAR'S SIGNATURE <i>William Williams, M.D.</i>	
25. FUNERAL DIRECTOR ADDRESS <i>Flynn &amp; Fleming 1426 Light St.</i>	

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See Document File 50-6380

8-24-50

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50 6381

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6381  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Willie Hill</b>		2. DATE OF DEATH <b>July 18, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>20yrs</b>		D. STREET ADDRESS (If rural, give location) <b>921 S. Fremont Ave</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 4, 1907</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Stevedoring</b>	9. AGE (In years; last birthday) <b>43</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-09-6768</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
18. 002X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Tuberculosis</b>		11. BIRTHPLACE (State or foreign country) <b>Va</b>	
19A. DATE OF OPERATION		14. MOTHER'S MAIDEN NAME <b>Hattie Taplin</b>	
19B. MAJOR FINDINGS OF OPERATION		17. INFORMANT <b>Baltimore City Hospital Records</b> <b>4940 Eastern Ave.</b>	
19C. TIME (Month) (Day) (Year) (Hour) INJURY		17. ADDRESS	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21F. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <b>March 18, 1950</b> , to <b>July 18, 1950</b> , that I last saw the deceased alive on <b>July 18, 1950</b> , and that death occurred at <b>12.50 PM</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>C. Rogers</b>		23B. ADDRESS <b>4940 Eastern Ave</b>	
23C. DATE SIGNED <b>7-19-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Williams, M.D.</b>	
FURNERAL DIRECTOR <b>Chas. Harper Carwell</b>		ADDRESS <b>512</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEED

WATLEY  
CONGRESS

BOND

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6382

000  
6382  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Austin M. Lee</u>		2. DATE OF DEATH <u>July 19 1950</u>	
3. PLACE OF DEATH: A. <u>Baltimore City, Maryland Balto. City</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>15 South Duncan Street</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore City</u> <u>1-05</u>	
c. Length of stay in Baltimore <u>Life</u>		D. STREET ADDRESS (If rural, give location) <u>15 South Duncan Street</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 1, 1891</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>In General</u>	9. AGE (In year: last birthday) <u>59</u> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Buckingham Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Austin</u>		14. MOTHER'S MAIDEN NAME <u>Cidney Austin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212.12.6162</u>	
17. INFORMANT <u>Daisy Austin</u>		ADDRESS <u>15 S. Duncan St</u>	

18. <u>410X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial &amp; aortic insufficiency</u> DUE TO _____ (A) _____ ANTECEDENT CAUSES <u>Cardioma undetermined</u> (B) _____ DUE TO _____ (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr -</u>
--	--	---

19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>50</u> , to <u>July 10</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>July 12, 1950</u> , and that death occurred at <u>3:00 p.m.</u> , from the causes and on the date stated above.				
23A. SIGNATURE <u>W. E. Brewster, M.D.</u>	23B. ADDRESS <u>141 Airguth</u>	23C. DATE SIGNED <u>7/21/50</u>		

24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/22/1950</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Brooklyn A.A.Co.Md</u>
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 21 1950</u>	REGISTRAR'S SIGNATURE <u>Wilmington Williams, M.D.</u>	25. FUNERAL DIRECTOR <u>Elroy O. Wilson</u>	ADDRESS <u>1000 Beautyview</u>

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MEDICAL CERTIFICATION

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100% HAG  
100% HAG



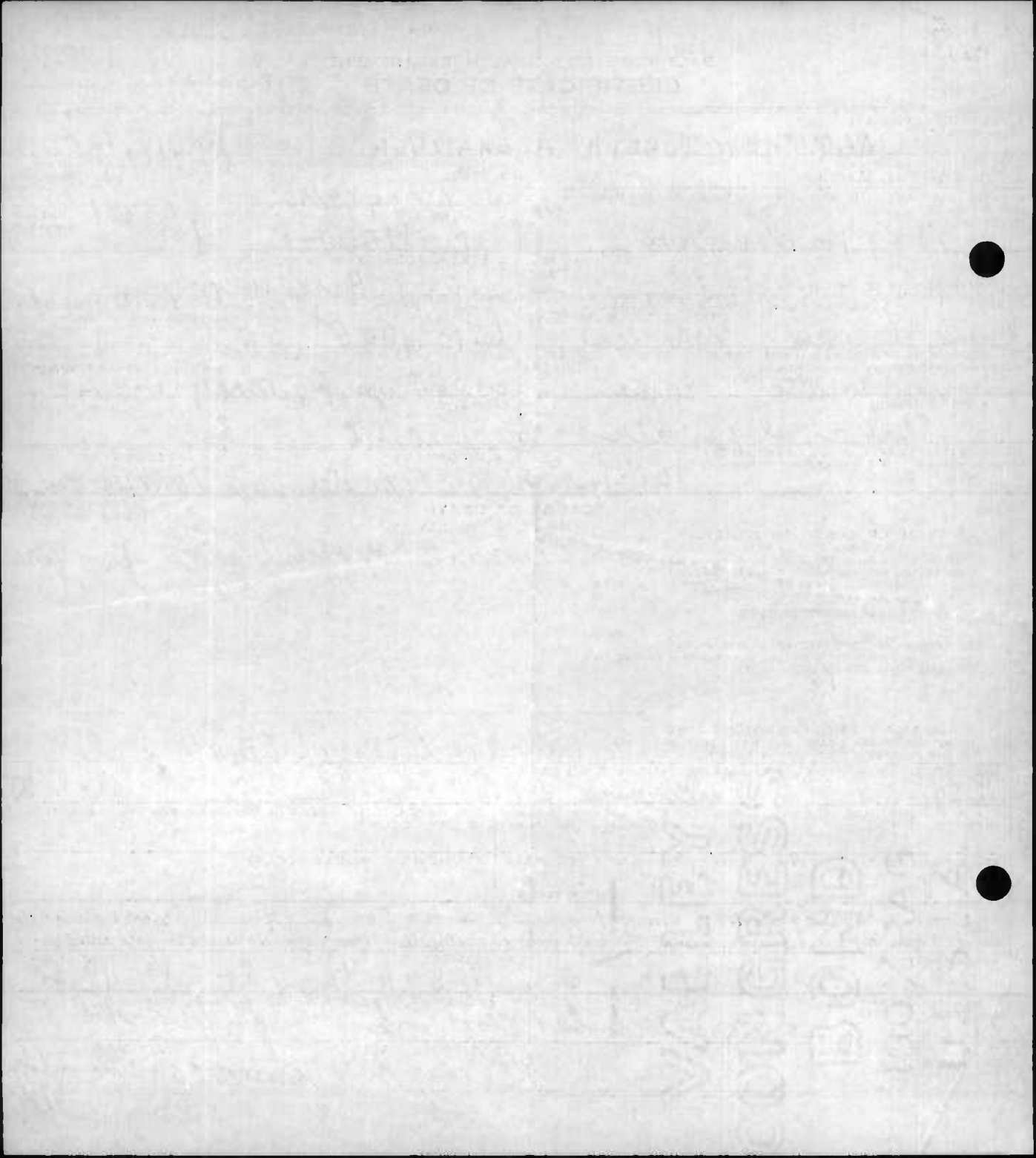
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6383

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6383  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MATTHEW JOSEPH ALEXANDER</b>				2. DATE OF DEATH <b>July 19, 1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1039 Harlem Ave</b>				C. CITY OR TOWNSHIP (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
C. Length of stay in Baltimore <b>41</b>				D. STREET ADDRESS (If rural, give location) <b>1039 Harlem Ave</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>6-10-1895</b>	9. AGE (in years, last birthday) <b>55</b>	10. Under 1 Year Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) <b>Georgetown, Kentucky</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House painter</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Same</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elisha Alexander</b>				14. MOTHER'S MAIDEN NAME <b>Margaret ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-14-7618</b>			
17. INFORMANT <b>Mrs Ruth Alexander</b>				ADDRESS <b>1029 Harlem Ave</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>155X ?</b>				CAUSE OF DEATH <b>Carcinoma of liver &amp; gall bladder</b>			
DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>two years</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>				(B) ...			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>C. valvular disease of heart</b>				(C) ...			
19A. DATE OF OPERATION <b>5-24-50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of liver &amp; gall bladder</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (If in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6-5-</b> , 19 <b>50</b> to <b>7-19-</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7-19-</b> , 19 <b>50</b> and that death occurred at <b>10:00 a.m.</b> , from the causes and on the date stated above.							
23A. SIGNATURE <b>John E. J. Camper</b>				23B. ADDRESS <b>639 N. Carey St</b>		23C. DATE SIGNED <b>7-19-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/20/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Elroy O. Wilson</b>		ADDRESS <b>1000 Brantly</b>	

MEDICAL CERTIFICATION



563  
 REA-43494  
 BIRTH NO. 6384

BALTIMORE CITY HEALTH DEPARTMENT  
 CERTIFICATE OF DEATH

50 6384  
 Registered No.

1. NAME OF DECEASED (Type or Print) Eugene Kennard			2. DATE OF DEATH July 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) Baltimore City Hospitals 4940 Eastern Avenue			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5300		
C. Length of stay in Baltimore life Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) No Home 2 Belmont Avenue, Woodlawn		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Dec. 4, 1860		9. AGE (In years last birthday) 89
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. House Builder		10B. KIND OF BUSINESS OR INDUSTRY self	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Kennard			14. MOTHER'S MAIDEN NAME Maria (Mariah) Clark		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Avenue		

18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH (A) Cerebral Vascular Hemorrhage DUE TO (B) Arteriosclerosis Generalized DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDER- LYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 4-3-1939, to 7-21-1950 that I last saw the deceased alive on 7-21-1950, and that death occurred at 8 A. m., from the causes and on the date stated above.				
23A. SIGNATURE O. H. Crogen	M. D. 4940 Eastern Avenue	23B. ADDRESS	23C. DATE SIGNED 7-21-50	

24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 7/24/50	24C. NAME OF CEMETERY OR CREMATORY New Cathedral	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
DATE RECEIVED BY LOCAL REGISTRAR JUL 21 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Hm. Cook, Inc. 1217 St. Paul Street	

10-1-73

Page 2 of 2

Enclosure

Self-Inspection Report

1. Self-Inspection Report

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63 REA-139685		BALTIMORE CITY HEALTH DEPARTMENT		50 6385	
6385		CERTIFICATE OF DEATH		Registered No.	
1. NAME OF DECEASED (Type or Print) <b>Charles William Streett</b>			2. DATE OF DEATH <b>July 20, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1246 Sargent Street</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 16, 1888</b>	9. AGE (In years last birthday) <b>61</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Max Streett</b> (D)		14. MOTHER'S MAIDEN NAME <b>(D) Lydia O. Williams</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes, no or unknown</b>		16. SOCIAL SECURITY NO. <b>214-01-9797</b>		17. INFORMANT <b>Baltimore City Hospitals</b> <b>Records: 4940 Eastern Avenue</b>	
18. I <b>151X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> DUE TO CAUSE OF DEATH (A) <b>Cardiac Arrest</b> (B) <b>Carcinomatosis-Liver, Skin and Lymph Nodes, secondary to Carcinoma of Stomach</b> DUE TO (C) <b>Nodes, secondary to Carcinoma of Stomach</b> INTERVAL BETWEEN ONSET AND DEATH			19. DATE OF OPERATION <b>July 20, 1950</b> 20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		
19A. DATE OF OPERATION <b>July 20, 1950</b>			19B. MAJOR FINDINGS OF OPERATION <b>Obstruction due to Carcinoma of Stomach</b>		
21A. ACCIDENT WAS UNDER- LYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 13, 1950</b> to <b>July 20, 1950</b> that I last saw the deceased alive on <b>July 20, 1950</b> and that death occurred at <b>10:05 A.M.</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>Wm. Cook Inc.</b> M. D.		23B. ADDRESS <b>4940 Eastern Avenue</b>		23C. DATE SIGNED <b>July 20, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>			
24F. REGISTRAR'S SIGNATURE <b>Wm. Cook Inc.</b>		24G. FUNERAL DIRECTOR ADDRESS <b>Wm. Cook Inc. 1217 St. Paul St.</b>			
VS 150 <b>57424</b> <b>46B</b>					

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642  
6386BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6386

Registered No.

1. NAME OF DECEASED (Type or Print) <b>ELIZABETH GRALESKA</b>		2. DATE OF DEATH <b>7-19-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>3013 Chesterfield AVE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) <b>BALTIMORE 26-03</b>	
6. Length of stay in Baltimore <b>55</b>		D. STREET ADDRESS (If rural, give location) <b>3013 Chesterfield AVE</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10-4-1888</b>
9. AGE (in years last birthday) <b>62</b>		10. Under 1 Year Months: Days: Hours: Min.	11. Under 24 Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HELENA ZULTY</b>		ADDRESS <b>3013 Chesterfield</b>	
18. <b>443X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cerebro-Vascular Disease</b> CAUSE OF DEATH <b>Cerebral Hemorrhage</b> DUE TO <b>Hypertensive Cerebro-Vascular Disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19. DATE OF OPERATION <b>0</b>			
19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDER- Lying <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 11, 1950</b> , to <b>July 18, 1950</b> , that I last saw the deceased alive on <b>July 18, 1950</b> , and that death occurred at <b>13:45 m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>William H. Fushy</b>		23B. ADDRESS <b>11 E. Chase St</b>	
23C. DATE SIGNED <b>7-21-50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-22-50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary</b>		24D. LOCATION (City, town, or county) (State) <b>German Hill Rd.</b>	
25. FUNERAL DIRECTOR <b>Charles F. Hill</b>		ADDRESS <b>1501 E. Lombard</b>	

937

2 of 30

ALBERTA

MT.

Calgary

30th September 1941

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to 4th St.

to 4th St.

W.A.

to 4th St.

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BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No. **50 6387**

**6387**  
 BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ELIZABETH Josephine FRANZ</b>		2. DATE OF DEATH <b>7/19/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>26-01</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE - 6</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>4309 LA SALLE AVE.</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>MAR. 8-1933</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>STUDENT</b>	9. AGE (In years last birthday) <b>17</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD H. FRANZ</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH MUELLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MOTHER</b>		ADDRESS <b>SAME</b>	

18. <b>754.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CONGENITAL HEART DEFORMITY (EISEN MENGER (complex))</b> DUE TO WITH <b>RHEUMATIC HEART DISEASE</b>	CAUSE OF DEATH <b>CONGENITAL HEART DEFORMITY (EISEN MENGER (complex))</b> <b>RHEUMATIC HEART DISEASE</b>	INTERVAL BETWEEN ONSET AND DEATH <b>17YRS</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7/19/50</b>	19B. MAJOR FINDINGS OF OPERATION <b>CONGENITAL HEART DIS. &amp; Rheum. HEART DIS.</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>7/16/50</b> , 19 <b>50</b> to <b>7/19</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7/19</b> , 19 <b>50</b> , and that death occurred at <b>8:00P</b> m., from the causes and on the date stated above.		
23A. SIGNATURE <b>John F. Strohan</b> M. D.	23B. ADDRESS <b>University Hosp.</b>	23C. DATE SIGNED <b>7/19</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-22-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	25. FUNERAL DIRECTOR <b>L. J. Luck</b>	ADDRESS <b>5305 Harford Rd</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>		
REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		

MEDICAL CERTIFICATION

157E

100-0000

STATE OF TEXAS

County of \_\_\_\_\_



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 6388

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Edward McCullum**

2. DATE  
OF  
DEATH

**July 11, 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

**Sinai Hospital**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY **Baltimore**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore ESSEX Md**

D. STREET ADDRESS (If rural, give location)

**1245 Willow Rd. # 22**

**5300**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

**S**

Yrs.  
Mos.  
Days

8. DATE OF BIRTH

**July 8, 1950**

9. AGE (In years last birthday) If Under 1 Year Months: Days: If Under 24 Hours Hours: Min.

**2**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Baltimore, Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**William T. McCullum**

14. MOTHER'S MAIDEN NAME

**Vera May Senter**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Hospital Records**

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Tracheo-esophageal fistula congenital, postoperative**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Absent Left Lung.**

(C) **Multiple congenital anomalies**

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

**7-10-50**

19B. MAJOR FINDINGS OF OPERATION

**Tracheo-esophageal fistula & associated anomalies**

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-10**, 19**50**, to **7-11**, 19**50** that I last saw the deceased alive on **7-11**, 19**50** and that death occurred at **1:45** Am., from the causes and on the date stated above.

23A. SIGNATURE

**Judith S. Leland**

M. D.

23B. ADDRESS

**Sinai Hospital Baltimore**

23C. DATE SIGNED

**7-11-50**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

**JOHN HOPKINS MEDICAL SCHOOL JUL 14 1950**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

**Huntington Williams, Jr.**

25. FUNERAL DIRECTOR

**Commissioner of Health**

ADDRESS

**JUL 21 1950**

VS 150

**1578**

MEDICAL CERTIFICATION

STATE OF TEXAS  
COUNTY OF DALLAS

Know all men by these presents, that

JOHN A. SMITH

do hereby certify that

JOHN A. SMITH

is the owner of the following described land

to-wit:

Section 10, Township 10N, Range 10E, Meridian 10N

containing 40 acres of land

more or less, situated in the County of Dallas, State of Texas

and is the same

as shown on the plat

of the same

as shown on the plat

of the same

as shown on the plat

of the same

as shown on the plat

of the same

as shown on the plat

of the same

as shown on the plat

of the same

JOHN A. SMITH

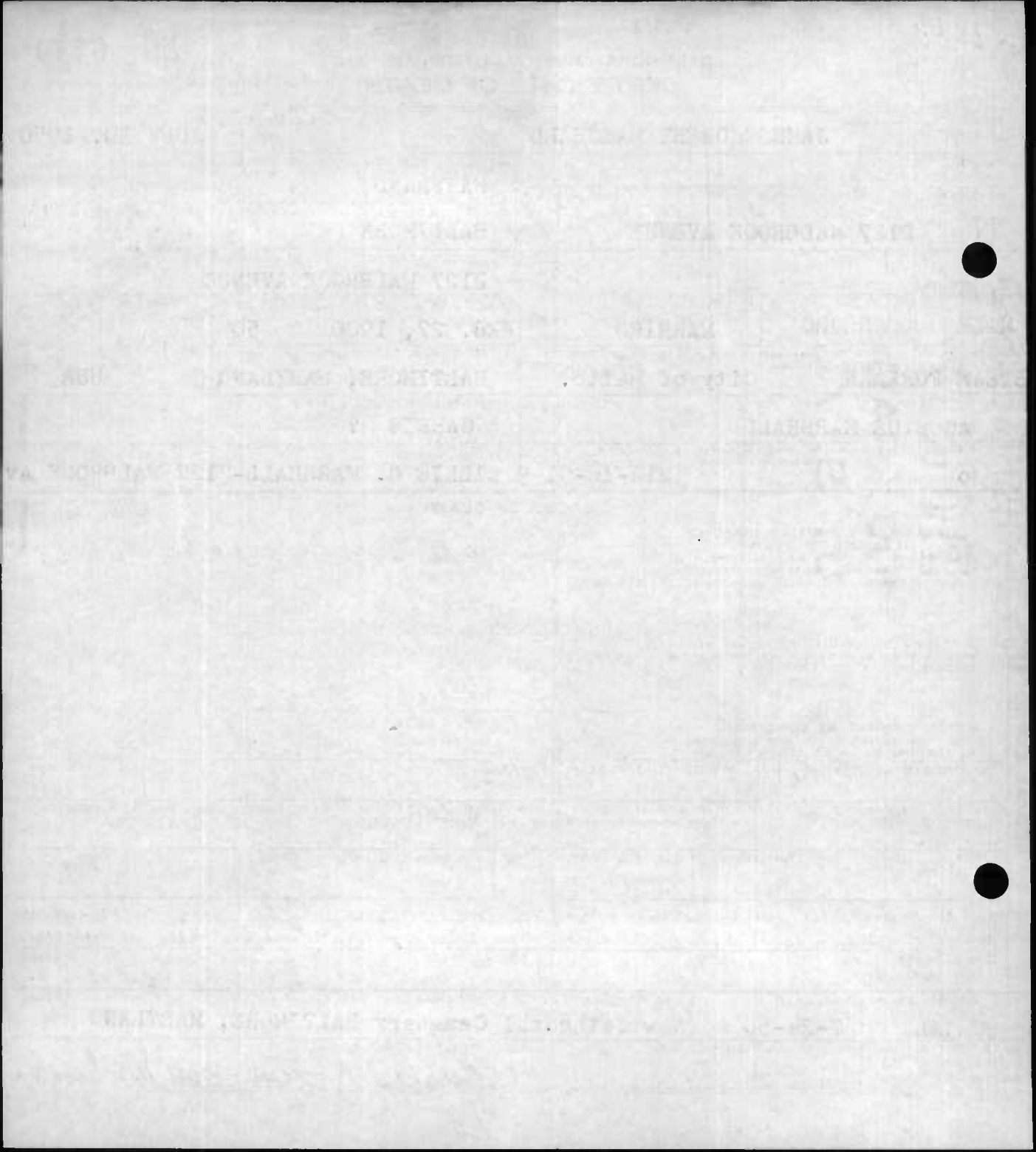


624  
6389BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6389

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JAMES ROBERT MARSHALL</b>		2. DATE OF DEATH <b>JULY 20, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY _____			
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2127 WALBROOK AVENUE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE</b>			
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>2127 WALBROOK AVENUE</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB. 27, 1900</b>	9. AGE (In years, last birthday) <b>50</b>	If Under 1 Year Months: Days Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEAM FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Balto.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>AGUSTUS MARSHALL</b>			
14. MOTHER'S MAIDEN NAME <b>CARRIE ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-16-9149</b>		17. INFORMANT ADDRESS <b>LILLIE G. MARSHALL-2127 WALBROOK AV</b>			
18. <b>430.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Sub-acute Bact. Endocarditis</b> DUE TO <b>Oral Sepsis</b> DUE TO <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.					
INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>					
19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 18</u> , 19 <u>50</u> , to <u>July 20</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>July 19</u> , 19 <u>50</u> , and that death occurred at <u>4 A. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <i>W. Donald Bando</i>		23b. ADDRESS M. D. <u>2445 Druid Hill Ave</u>		23c. DATE SIGNED <u>July 21, 1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>7-24-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery BALTIMORE, MARYLAND</b>	
24d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>		24e. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 21 1950</b>			
24f. REGISTRAR'S SIGNATURE <i>W. H. Williams</i>		24g. FORMAL DIRECTOR ADDRESS <i>Charles R. Law - 802 Madison Ave</i>			
52393					



500  
50 6390

LELAND S. HAHN

BALTIMORE CITY HEALTH DEPARTMENT

50 6390

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)*Leland S. Hahn*2. DATE  
OF  
DEATH

7-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or location)*Univ. Hosp.*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*W*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)*Single*

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

*Md.*

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

*Baltimore**4-02*

D. STREET ADDRESS (If rural, give location)

*653 W. Lombard St.*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

*Laborer*

10B. KIND OF BUSINESS OR INDUSTRY

*?*

8. DATE OF BIRTH

*Sept. 27, 1899*

9. AGE (In years last birthday)

*50*

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

11. BIRTHPLACE (State or foreign country)

*Maryland*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Edward J. Hahn*

14. MOTHER'S MAIDEN NAME

*Katherine Link*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

*no*

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Mr. Edward A. Hahn - 840 Woodington Rd.*18. *002X*

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A)

*Bilateral Fur Adenoid*  
*Taberculosis - organism identified*

DUE TO

(B)

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7-16*, 19*50*, to *7-20*, 19*50*, that I last saw the deceased alive on *7-20*, 19*50*, and that death occurred at *10 A* m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

*Burial**7/22/50**Loudon Park**Baltimore, Md.*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*21 1950**Huntington Williams, Jr.**Thm. J. Dickner & Sons - Balto Md.*

VS 150

97099389

1213

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death	
6. Place of Birth		7. Occupation		8. Cause of Death		9. Manner of Death		10. Signature of Registrar	
11. Signature of Medical Officer		12. Signature of Coroner		13. Signature of Police Officer		14. Signature of Burial Officer		15. Signature of Witnesses	
16. Signature of Deceased		17. Signature of Next of Kin		18. Signature of Priest		19. Signature of Minister		20. Signature of Chaplain	
21. Signature of Undertaker		22. Signature of Funeral Director		23. Signature of Cemetery		24. Signature of Burial Ground		25. Signature of Interment	
26. Signature of Burial Officer		27. Signature of Registrar		28. Signature of Medical Officer		29. Signature of Coroner		30. Signature of Police Officer	
31. Signature of Burial Officer		32. Signature of Registrar		33. Signature of Medical Officer		34. Signature of Coroner		35. Signature of Police Officer	
36. Signature of Burial Officer		37. Signature of Registrar		38. Signature of Medical Officer		39. Signature of Coroner		40. Signature of Police Officer	
41. Signature of Burial Officer		42. Signature of Registrar		43. Signature of Medical Officer		44. Signature of Coroner		45. Signature of Police Officer	
46. Signature of Burial Officer		47. Signature of Registrar		48. Signature of Medical Officer		49. Signature of Coroner		50. Signature of Police Officer	
51. Signature of Burial Officer		52. Signature of Registrar		53. Signature of Medical Officer		54. Signature of Coroner		55. Signature of Police Officer	
56. Signature of Burial Officer		57. Signature of Registrar		58. Signature of Medical Officer		59. Signature of Coroner		60. Signature of Police Officer	
61. Signature of Burial Officer		62. Signature of Registrar		63. Signature of Medical Officer		64. Signature of Coroner		65. Signature of Police Officer	
66. Signature of Burial Officer		67. Signature of Registrar		68. Signature of Medical Officer		69. Signature of Coroner		70. Signature of Police Officer	
71. Signature of Burial Officer		72. Signature of Registrar		73. Signature of Medical Officer		74. Signature of Coroner		75. Signature of Police Officer	
76. Signature of Burial Officer		77. Signature of Registrar		78. Signature of Medical Officer		79. Signature of Coroner		80. Signature of Police Officer	
81. Signature of Burial Officer		82. Signature of Registrar		83. Signature of Medical Officer		84. Signature of Coroner		85. Signature of Police Officer	
86. Signature of Burial Officer		87. Signature of Registrar		88. Signature of Medical Officer		89. Signature of Coroner		90. Signature of Police Officer	
91. Signature of Burial Officer		92. Signature of Registrar		93. Signature of Medical Officer		94. Signature of Coroner		95. Signature of Police Officer	
96. Signature of Burial Officer		97. Signature of Registrar		98. Signature of Medical Officer		99. Signature of Coroner		100. Signature of Police Officer	

650  
50 6391BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6391  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Esma Brown</i>		2. DATE OF DEATH <i>7/21/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Maryland General Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>Maryland General Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore #16 15-09</i>	
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>3105 Chelsea Terrace</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>	8. DATE OF BIRTH <i>6/27/85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	9. AGE (In years last birthday) <i>65</i>
13. FATHER'S NAME <i>Josiah Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Lowe</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS <i>Mrs. Carl Hamilton - 3105 Chelsea Terr.</i>	

18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral hemorrhage (Right hemiplegia)</i> DUE TO (A) <i>Cerebral hemorrhage (Right hemiplegia)</i> DUE TO (B) <i>Hypertensive Cardiovascular disease</i> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH <i>13 1/2 hours</i> <i>10 years</i>
---	--

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

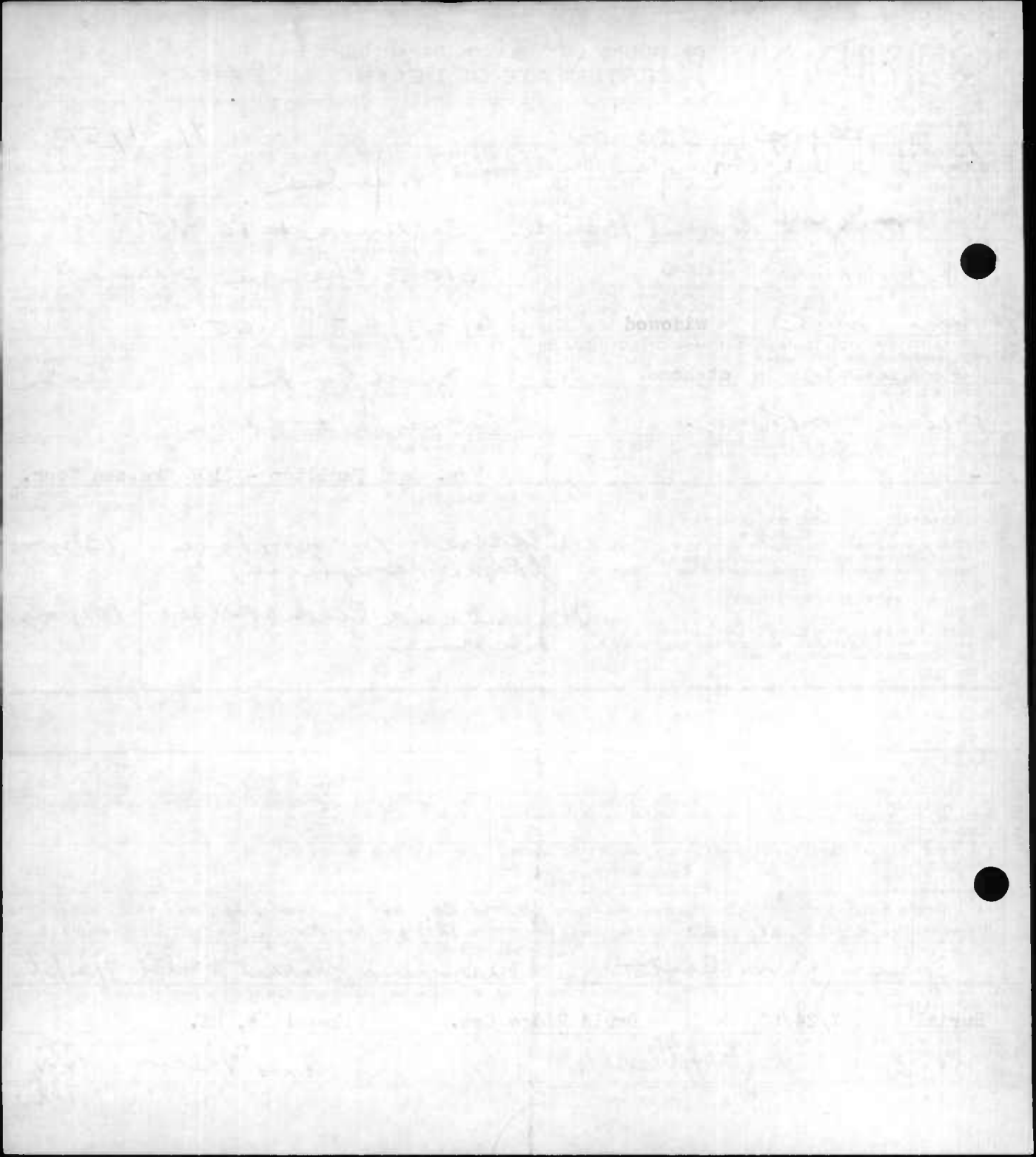
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT <input type="checkbox"/> WORK AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *July 20, 1950*, to *July 21, 1950*, that I last saw the deceased alive on *July 21, 1950*, and that death occurred at *12:30 a.m.*, from the causes and on the date stated above.

23A. SIGNATURE <i>Mary W. Clift</i>		23B. ADDRESS <i>Maryland General Hospital</i>		23C. DATE SIGNED <i>7/21/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/24/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>					

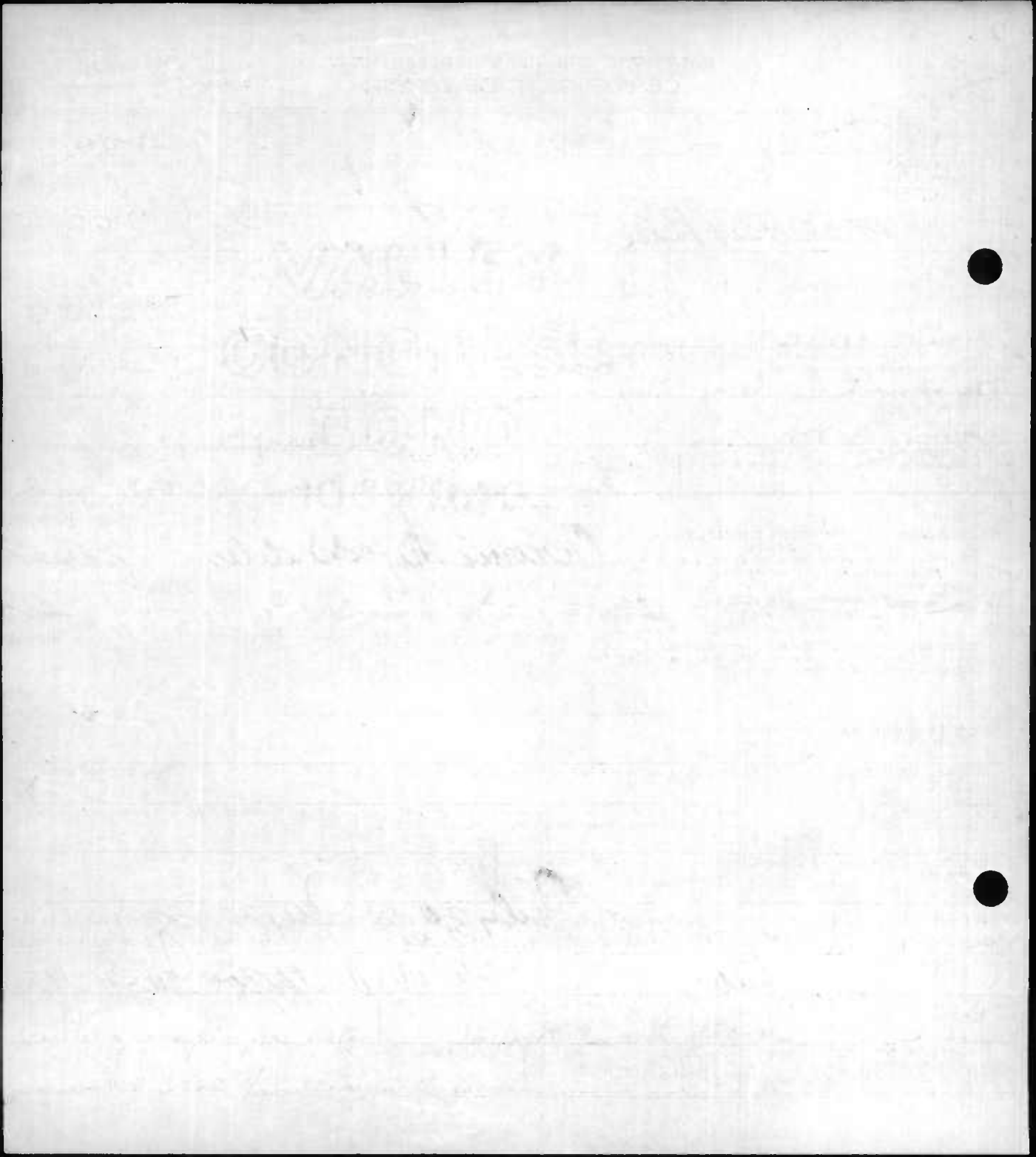
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 21 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Sicker</i>		25. FUNERAL DIRECTOR <i>Wm. J. Sicker &amp; Son</i>	
ADDRESS <i>937</i>					

VS 150









523

6393

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6393

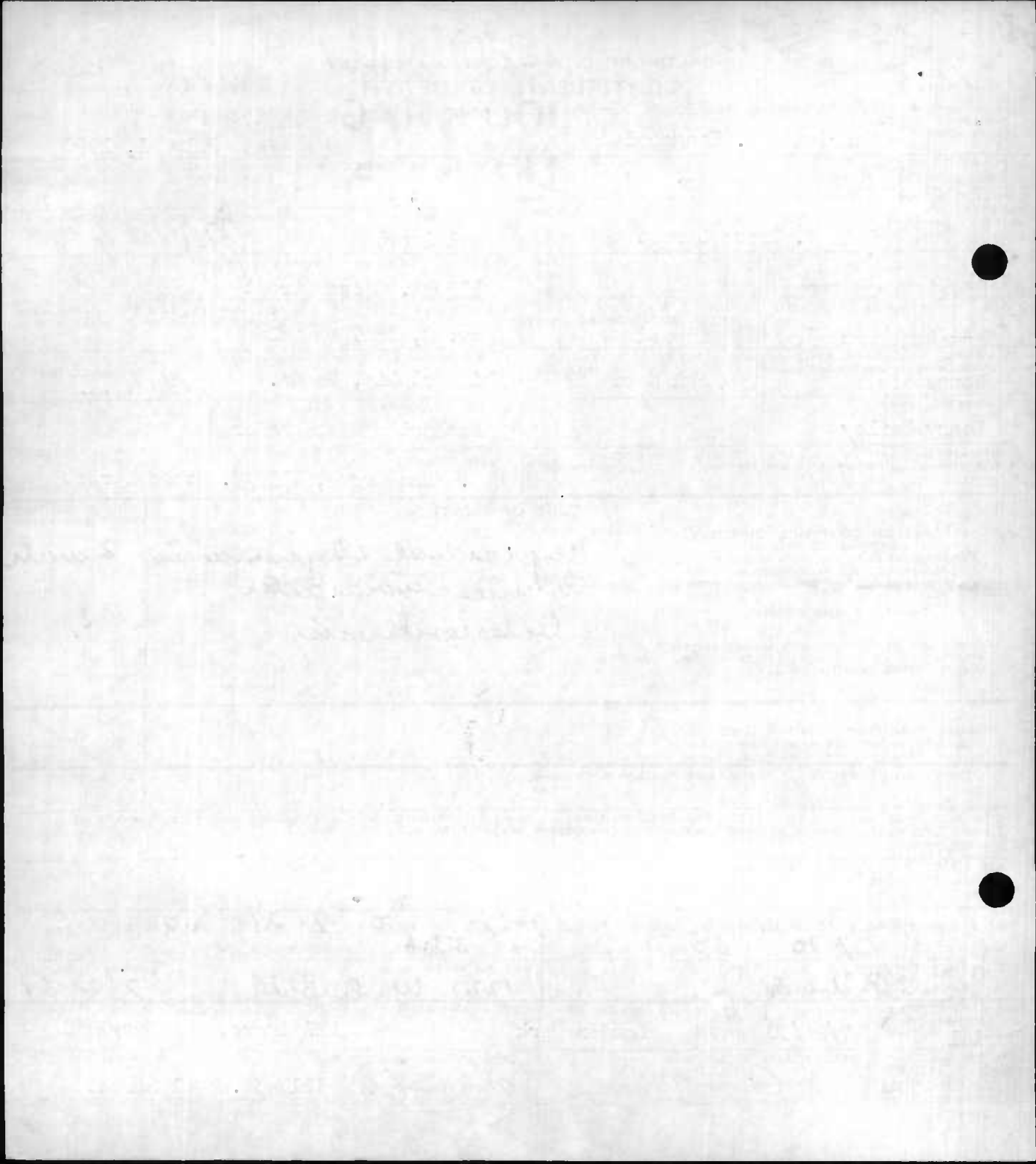
1. NAME OF DECEASED (Type or Print) <b>Henrietta L. Langgood</b>		2. DATE OF DEATH <b>July 21, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1139 W. Cross Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>21-0</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>1139 W. Cross Street</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Nov. 2, 1867</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	9. AGE (in years last birthday) <b>82</b>
13. FATHER'S NAME <b>Henry Bailey</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Penna.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo or unknown) (If yes, give war or dates of service) <b>no</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Katherine Gushenhofer</b>	
17. INFORMANT <b>Mrs. Rena Grove, 1139 W. Cross Street</b>		ADDRESS	

18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial degeneration</b> <b>Chronic Myocarditis</b> <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>?</b>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-17-</b> , 19 <b>50</b> , to <b>7-21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-20</b> , 19 <b>50</b> and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John P. Unwelf Jr.</b>		23B. ADDRESS <b>1227 Wash Blvd</b>		23C. DATE SIGNED <b>7-21-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/24/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>		24F. ADDRESS <b>1217 St. Paul Street</b>	

195-00306392

93D



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6394

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. MESSMER MESNER</b>		2. DATE OF DEATH <b>July 20, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>414 W. Fayette Street</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>July 16, 1881</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>night clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Fayette Hotel</b>	9. AGE (In years last birthday) <b>69</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Mesner</b>		14. MOTHER'S MAIDEN NAME <b>Caroline E. Silverzhan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-01-1925</b>	
17. INFORMANT		ADDRESS <b>Mrs. Florence E. Walter, 3323 English</b>	

18. <b>443X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>William J. Cook</i>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 20, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/24/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. FUNERAL DIRECTOR <b>Wm. Cook, Inc. 1217 St. Paul Street</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 22 1950</b>		REGISTRAR'S SIGNATURE <i>William J. Cook</i>			





BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6395  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Flora Moeller</b>		2. DATE OF DEATH <b>July 21/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>423 N. East Ave.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>423 N. East Ave.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore Md.</b>	
c. Length of stay in Baltimore <b>26yrs</b>		D. STREET ADDRESS (If rural, give location) <b>423 N. east Ave.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 14, 1878</b>
9. AGE (In years, last birthday) <b>72</b>		10. Under 1 Year Months: Days Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>---Bauerfeld</b>		14. MOTHER'S MAIDEN NAME <b>---Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Alfred Moeller, 423 N. East Ave.</b>		ADDRESS	
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardosis</b> DUE TO (A) <b>Arteriosclerotic cardiac vascular disease</b> DUE TO (B) <b>arteriosclerosis</b> (C) <b>Diabetes mellitus</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>5-1-1957</b> , to <b>7-21-1957</b> , that I last saw the deceased alive on <b>7-21-1957</b> , and that death occurred at <b>1:20 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>John J. Gould</b>		23B. ADDRESS <b>14 N. East Ave.</b>	
23C. DATE SIGNED <b>7-21-57</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 24/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 22 1950</b>		REGISTRAR'S SIGNATURE <b>William M. Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Philip's Funeral Home</b>		ADDRESS <b>2024 Orleans St.</b>	

1954-1955

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1954-1955

ADDITIONAL

REMOVE

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				50 6396 Registered No.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH	
Joseph Carfora				July 21-50	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Balto. City				A. STATE Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
927 N. Rose St.				Balto. 7-02	
C. Length of stay in Baltimore				D. STREET ADDRESS (If rural, give location)	
44 yrs.				927 N. Rose St.	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months Days
Male	White	Widowed	Dec. 23-1881	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Grocery Store			Italy		U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Lawrence Carfora			Angela Appenitta		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			17. INFORMANT ADDRESS		
(If yes, give war nr dates of service)			None Angela F. Carfora 927 N. Rose St.		
16. SOCIAL SECURITY NO.			18. CAUSE OF DEATH		
None			416X I		
DISEASE OR CONDITION LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) ...		
ANTECEDENT CAUSES			(B) ...		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(C) ...		
II			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
19A. DATE OF OPERATION			19B. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 14, 1950, to July 21, 1950, that I last saw the deceased alive on July 21, 1950, and that death occurred at 1 P. M., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
L. C. Doherty		5474 Kenwood Ave.		7/21/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 24-50		Holy Redeemer	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Balto. Md.		Duggel Bros.		1800 E. Lombard St.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
JUL 22 1950		Thurston Williams, M.D.		Duggel Bros. 1800 E. Lombard St.	
VS 150					
2906A					
95B					

MEDICAL CERTIFICATION



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

50 6397

BIRTH NO. _____			1. NAME OF DECEASED (Type or Print) <b>MARMADUKE TILDEN</b>			2. DATE OF DEATH <b>JULY 21, 1950</b>			
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Calverly 33</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>						C. CITY OR TOWN (If outside corporate limits, give RURAL and give township) <b>BALTIMORE</b>			
C. Length of stay in Baltimore <b>30 yrs</b>						D. STREET ADDRESS (If rural, give location) <b>WARRINGTON APTS, BALTO, 18.</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>		8. DATE OF BIRTH <b>NOV. 6, 1923</b>		9. AGE (In years last birthday) <b>76</b>		10. Under 1 Year Months: Days	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Finance</b>		11. BIRTHPLACE (State or foreign country) <b>Jersey City, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MARMADUKE TILDEN (D)</b>						14. MOTHER'S MAIDEN NAME <b>MARY BROADLEY (D)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS _____			

18. <b>331X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH  (A) <b>Cerebral Hemorrhage</b> DUE TO  (B) <b>As</b> DUE TO  (C) <b>Aspiration Pneumonia</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>3 Days</b>    <b>3 Days</b>
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19A. DATE OF OPERATION <b>✓</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>JULY 19, 1950</b> , to <b>JULY 21, 1950</b> , that I last saw the deceased alive on <b>JULY 21, 1950</b> , and that death occurred at <b>9:50 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Wallace L. Zentgraf, M.D.</b>		23B. ADDRESS <b>Union Memorial Hospital</b>		23C. DATE SIGNED <b>21 July 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 22/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pauling</b>	
24D. LOCATION (City, town, or county) <b>Pauling, Md.</b>		24E. LOCATION (State) <b>Md.</b>		24F. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 22 1950</b>	
24G. REGISTRAR'S SIGNATURE <b>William J. Williams, M.D.</b>		24H. FUNERAL DIRECTOR <b>Stewart M. Smith</b>		24I. ADDRESS <b>Balto.</b>	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



500  
50 6398

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6398  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Betty Nahn</i>		2. DATE OF DEATH <i>July 20, 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>Luthern Hospital Of Baltimore</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i> <i>26-44</i>	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>3601 Roberts Place</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Jan. 14, 1883</i>
10A. USUAL OCCUPATION (Give kind of work and place of work, if not identified) <i>Confectionary Store</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>	9. AGE (In years last birthday) <i>67</i> If Under 1 Year Months Days If Under 24 Hours Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Forcheimer</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Hilda Pollack</i>		ADDRESS <i>3601 Roberts Place</i>	

18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebrovascular Hemorrhage</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Hypertensive Cardiovascular Disease</i> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <i>Cerebrovascular Hemorrhage</i> DUE TO (B) <i>Hypertensive Cardiovascular Disease</i> DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/20</i> 1950, to <i>7/20</i> 1950, that I last saw the deceased alive on <i>7/20</i> 1950, and that death occurred at <i>12:05</i> pm., from the causes and on the date stated above.					
23A. SIGNATURE <i>Jerome Gaher</i>		23B. ADDRESS <i>Luthern Hosp.</i>		23C. DATE SIGNED <i>7/20/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 23, 1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Workmen Circle Cemetery</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 22 1950</i>		REGISTRAR'S SIGNATURE <i>Wm. J. Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Sol Greenman</i>	
VS 150		2906A		ADDRESS <i>1126 W North Ave</i>	

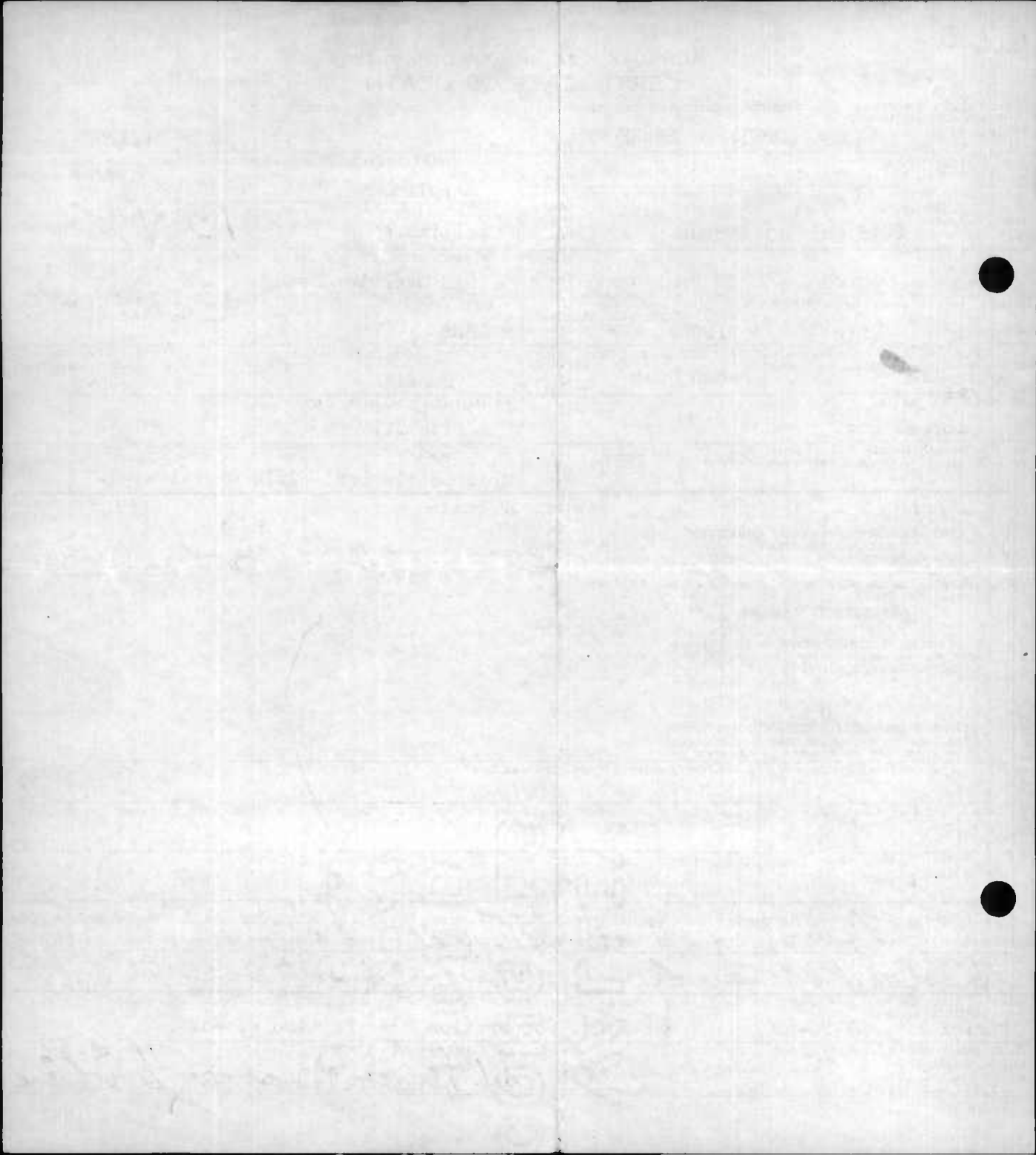


520  
50 6399BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6399  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>SOPHIE BANKS</b>		2. DATE OF DEATH <b>July 21, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>2486 Shirley Avenue</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>39 Yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>3518 Overview Road</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW W</b>	8. DATE OF BIRTH <b>1888</b>
9. AGE (In years, last birthday) <b>61</b>		10. Under 1 Year Months: Days: Hours: Min.	11. BIRTHPLACE (State or foreign country) <b>Russia</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>Borach Fox</b>	
14. MOTHER'S MAIDEN NAME <b>Glotta ???</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Lottie Barr- 3518 Overview Rd.</b>	

18. <b>148X</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <b>carcinoma of the larynx</b> DUE TO	<b>1 1/2 yrs.</b>
II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(B) _____ DUE TO	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	(C) _____	

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>May 1946</b> , to <b>July 21, 1950</b> , that I last saw the deceased alive on <b>July 21, 1950</b> and that death occurred at <b>4:50 p.m.</b> , from the causes and on the date stated above.		
23A. SIGNATURE <b>Richard Kolman</b>	23B. ADDRESS <b>3700 Park Heights Ave</b>	23C. DATE SIGNED <b>July 21, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-23-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mar Sinai Corporation</b>
24D. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		25. FUNERAL DIRECTOR <b>Sol. Levinson + Bros. W. North Ave</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>July 22, 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. H. Williams, M.D.</b>



635  
50 6400  
BIRTH NO.BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

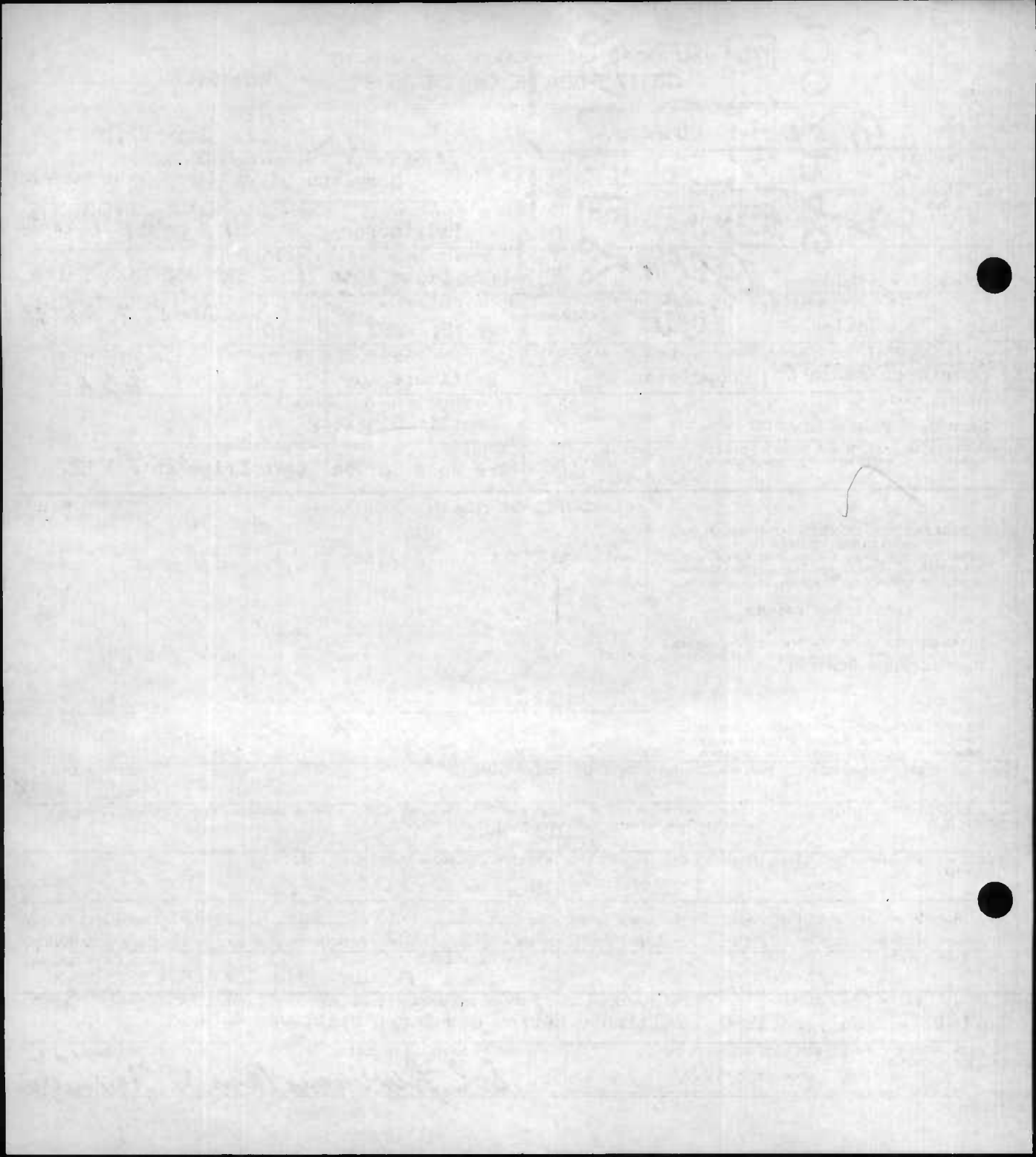
Registered No. 50 6400

1. NAME OF DECEASED (Type or Print) <b>Lester Gordon</b>			2. DATE OF DEATH <b>July 21, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <b>Lake Drive Apts Apt 1 EE</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>Lake Drive Apts Apt 1 EE 903 Lake Drive</b>			E. AGE (In years last birthday) <b>70</b>		
F. SEX <b>Male</b>			G. COLOR OR RACE <b>White</b>		
H. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>			I. DATE OF BIRTH <b>May 15, 1880</b>		
J. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mag Sportswear Business</b>			K. KIND OF BUSINESS OR INDUSTRY <b>Proprietor</b>		
L. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>			M. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
N. FATHER'S NAME <b>Samuel Graham Gordon</b>			O. MOTHER'S MAIDEN NAME <b>Cecelia Ginsberg</b>		
P. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			Q. SOCIAL SECURITY NO. <b>065-10-8669</b>		
R. INFORMANT <b>Mrs Rose Gordon</b>			S. ADDRESS <b>Lake Drive Apts 1 EE</b>		

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Coronary Artery Disease</b> DUE TO		<b>4 years</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>General Arteriosclerosis</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10/15</b> , 19 <b>49</b> , to <b>7/21</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/21</b> , 19 <b>50</b> , and that death occurred at <b>1 A. m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>22 July 1950</b>		23B. ADDRESS <b>2300 Eubank Rd</b>		23C. DATE SIGNED <b>7/21/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 23, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 22 1950</b>		REGISTRAR'S SIGNATURE <b>William Williams</b>		25. FUNERAL DIRECTOR <b>Sol Levinson</b>		ADDRESS <b>1126 Bus W North ave</b>	
<b>27-1061</b>		<b>290 4G</b>		<b>6390</b>		<b>94a</b>	

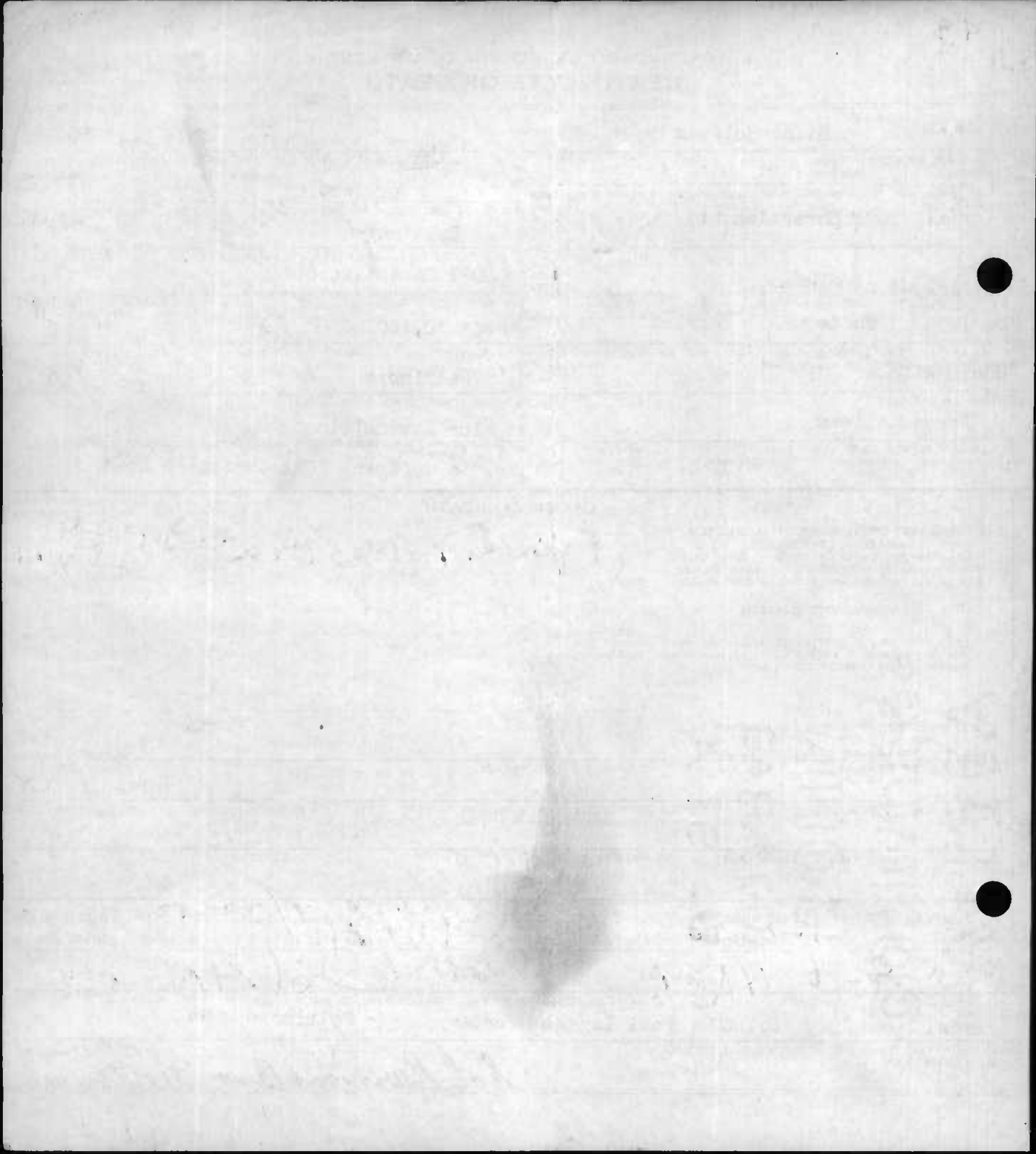




1. NAME OF DECEASED (Type or Print)		Hilda Hoffman		2. DATE OF DEATH		July 22, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE 2021 Christian St				C. CITY OR TOWN (If outside corporate limits, write full name and township) Baltimore 20-03			
C. Length of stay in Baltimore Yrs. Mos. Days				D. STREET ADDRESS (If rural, give location) 2021 Christian St			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept 30, 1902	9. AGE (In years last birthday) 47	10. Under 1 Year Months: Days:	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Kellman				14. MOTHER'S MAIDEN NAME Rica Rosenstein			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Melvin Hoffman 2021 Christian St			

<p>18. <b>443X</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p><b>CAUSE OF DEATH</b></p> <p>(A) <i>Myocardial infarction</i></p> <p>DUE TO</p> <p>(B)</p> <p>DUE TO</p> <p>(C)</p>	<p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><i>1 day</i></p>

MEDICAL	19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
	22. I hereby certify that I attended the deceased from 7/23/50, that I last saw the deceased alive on 7-21, 1950 and that death occurred at 8:15 P.M. from the causes and on the date stated above.					
23A. SIGNATURE <i>Robert H. [Signature]</i>		23B. ADDRESS <i>1036 [illegible] Ave</i>		23C. DATE SIGNED <i>July 23, 1950</i>		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE July 23, 1950		24C. NAME OF CEMETERY OR CREMATORY Bnai Israel Cemetery		
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Md		24F. DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1950		
24G. REGISTRAR'S SIGNATURE <i>William [illegible]</i>		24H. FUNERAL DIRECTOR <i>Sol [illegible]</i>		24I. ADDRESS 1126 W North Ave		

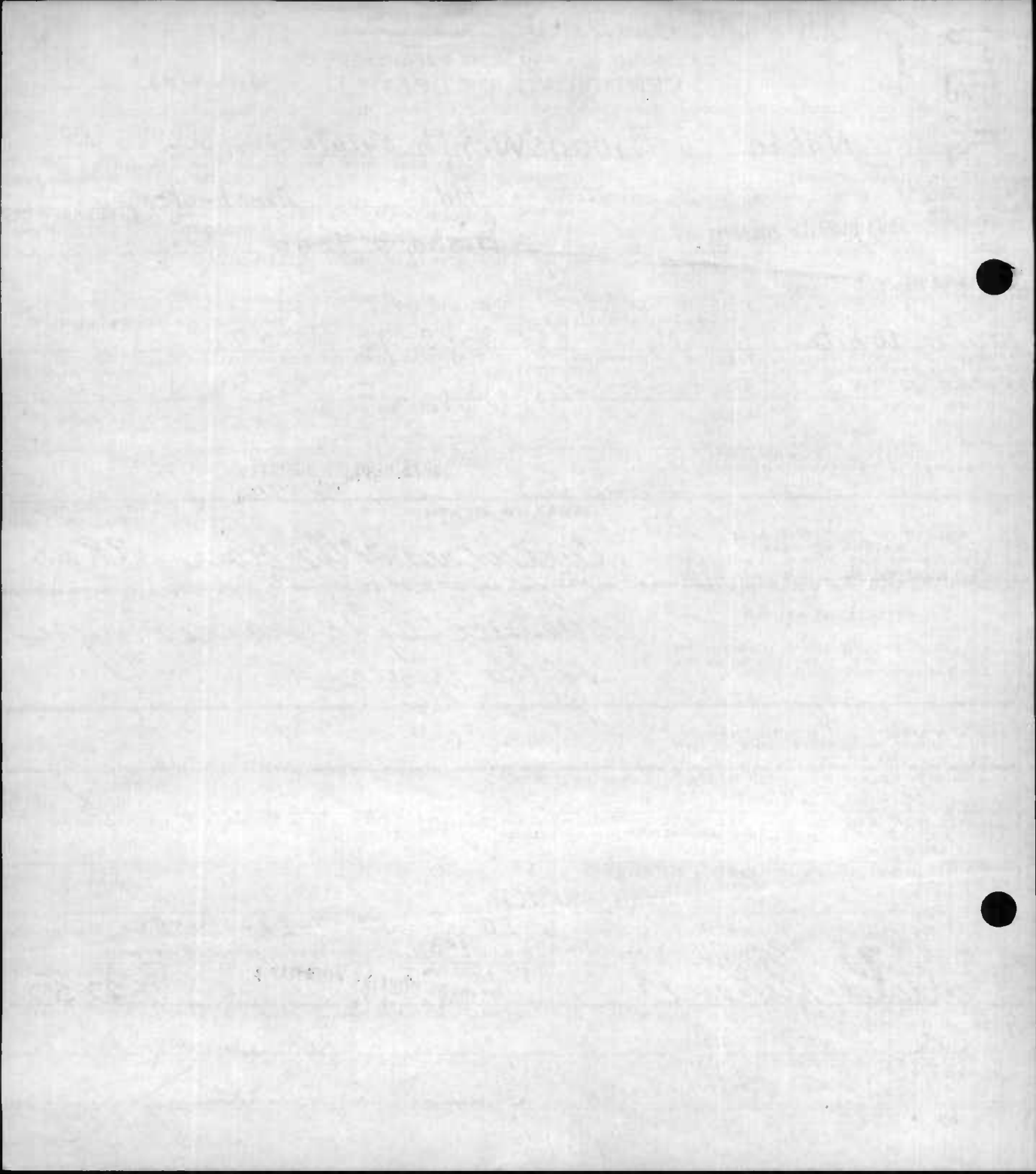


432  
0 6402  
CERTIFICATE CORRECTED 8-8-50BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6402  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Noble Bloodsworth, 542672</i>			2. DATE OF DEATH <i>JUL 22 1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Dorchester</i>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>			C. CITY, OR TOWN (If outside corporate limits, write RURAL and give township) <i>Bishops Head, Cambridge</i>		
D. STREET ADDRESS (If rural, give location) <i>5900</i>					
5. SEX <i>male</i>			6. COLOR OR RACE <i>white</i>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>			8. DATE OF BIRTH <i>3-20-93</i>		
9. AGE (in years last birthday) <i>57</i>			10. UNDER 1 Year Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Sea Food Fishing</i>		
11. BIRTHPLACE (State or foreign country) <i>Dorchester Co., Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13. FATHER'S NAME <i>Andrew Bloodsworth</i>			14. MOTHER'S MAIDEN NAME <i>Cora Granville</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Yes, no or unknown</i>			16. SOCIAL SECURITY NO. <i>216-1674-44</i>		
17. INFORMANT <i>JOHNS HOPKINS HOSPITAL</i>			ADDRESS		

18. <i>155X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) <i>Carcinoma of the Liver</i> DUE TO (B) <i>Bennet's Cirrhosis</i> DUE TO (C) <i>of the Liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>?8 mo.</i> <i>6 yrs</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>7-22-50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>6-30-</i> , 1950 to <i>7-22-</i> , 1950 that I last saw the deceased alive on <i>7-22-</i> , 1950 and that death occurred at <i>123A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>David R. Peters</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>7-22-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>4-25-50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Leander</i>	
24D. LOCATION (City, town, or county) (State) <i>Leander</i>		25. FUNERAL DIRECTOR <i>James J. Sullivan</i>		ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 22 1950</i>		REGISTRAR'S SIGNATURE <i>Trustington Williams, M.D.</i>			



400

6403

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6403

1. NAME OF DECEASED (Type or Print) <b>MELVIN MILLARD RILEY</b>		2. DATE OF DEATH <b>7-21-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Lutheran Hosp. of Md.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 13-00</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>3426 Oak Street</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Dec. 24-1907</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driller E. M. Kemp Manufacturing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>	
13. FATHER'S NAME <b>Robert Riley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Rosier</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-8962</b>	
17. INFORMANT <b>Mrs. Julia P. Buckley</b>		ADDRESS <b>1500 N. 36th St.</b>	

18. <b>416 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Gangrene of large bowel, ileum + peritonitis</b> DUE TO <b>Pulmonary + splenic infarcts</b> ANTECEDENT CAUSES <b>multiple emboli</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Rheumatic heart disease with congestive failure</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Gangrene of large bowel, ileum + peritonitis</b> DUE TO <b>Pulmonary + splenic infarcts</b> (B) <b>multiple emboli</b> DUE TO (C) <b>Rheumatic heart disease with congestive failure</b>	INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
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19A. DATE OF OPERATION <b>7-21-50</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>7-4-1950</b> to <b>7-21-1950</b> that I last saw the deceased alive on <b>7-21-1950</b> and that death occurred at <b>3:30 a.m.</b> from the causes and on the date stated above.		
23A. SIGNATURE <b>William S. Daly</b>	23B. ADDRESS <b>Lutheran Hosp. of Md.</b>	23C. DATE SIGNED <b>7-21-50</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 24-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Pine Grove</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 22 1950</b>	REGISTRAR'S SIGNATURE <b>William S. Daly</b>	25. FUNERAL DIRECTOR <b>Burgee Funeral Home 3631 Park Road</b>	

MEDICAL CERTIFICATION

Do not copy on any transmittal.

Gangrene due to circulatory  
collapse due to congestion  
heart failure, due to  
rheumatic heart disease

9.14.50

80

55-08087



652  
50 6404

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6404  
Registered No.

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Bertie Kaufman Frank.		July 20/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland Marlboro Apt.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland	
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
C. Length of stay in Baltimore 65yrs		D. STREET ADDRESS (If rural, give location)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH July 18th. 1867. 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 2	11. BIRTHPLACE (State or foreign country) Washington D.C.
13. FATHER'S NAME Charles Kaufman,		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sydney Frank,		ADDRESS 5531 Gynn Oak Ave	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 174X CAUSE OF DEATH Carcinoma of uterus & Metastasis	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from May 1950, to July 20, 1950, that I last saw the deceased alive on July 20, 1950, and that death occurred at 10:45 am., from the causes and on the date stated above.		
23A. SIGNATURE Holmick	23B. ADDRESS 4710 Liberty St	23C. DATE SIGNED 7/20/50

24A. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) Burial	24B. DATE July 23/50	24C. NAME OF CEMETERY OR CREMATORY Hebrew Friendship Cem Balto. Md	24D. LOCATION (City, town, or county) (State) Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR JUL 22 1950	REGISTRAR'S SIGNATURE Wilmington Williams, Md	25. FUNERAL DIRECTOR David Sontheimer	ADDRESS 1902 Eutaw Pl.

DECLARATION OF TESTIMONY

Page 20 of 20

1. I, [Name], do hereby declare that the foregoing is a true and correct copy of the original document.

2. I, [Name], do hereby declare that the foregoing is a true and correct copy of the original document.

3. I, [Name], do hereby declare that the foregoing is a true and correct copy of the original document.

4. I, [Name], do hereby declare that the foregoing is a true and correct copy of the original document.

5. I, [Name], do hereby declare that the foregoing is a true and correct copy of the original document.

6. I, [Name], do hereby declare that the foregoing is a true and correct copy of the original document.

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6405

1. NAME OF DECEASED <u>ALAN</u> (Type or Print) <u>ALLEN SCHWAB - (ALAN SCHWAB)</u>			2. DATE OF DEATH <u>July 21, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>1701 Eutaw Place</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
D. STREET ADDRESS (If rural, give location) <u>1701 Eutaw Place</u>			E. LENGTH OF STAY IN BALTIMORE Yrs. <u>0</u> Mos. <u>0</u> Days <u>0</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>Oct 20 / 1877</u>	9. AGE (In years last birthday) <u>72</u>	10. UNDER 1 Year Months: <u>9</u> Days: <u>0</u> Hours: <u>0</u> Min. <u>0</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>Petroleum Wholesale Agency Balto. Md.</u>	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Henry Schwab</u>			14. MOTHER'S MAIDEN NAME <u>Henrietta Straces</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

MEDICAL CERTIFICATION

18. <u>E976X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  DUE TO (A) <u>Gunshot wound of head</u>  DUE TO (B) _____  DUE TO (C) _____  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <u>July 21, 1950</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>home</u>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1701 Eutaw Place</u>		
21D. TIME (Month) (Day) (Year) (Hour) <u>July 21, 1950 9.00a.m.</u>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>firearms</u>		

I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE <u>William V. ...</u>		23B. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <u>July 21, 1950</u>
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE <u>July 23 / 50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Chel Shalom Cg</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>III 22 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. ...</u>	25. FUNERAL DIRECTOR <u>David ...</u>		ADDRESS <u>1502 Eutaw Pl</u>

V S 151 1-853.4 29063 100 164c

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Page No.

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERK

SIGNATURE OF JURY

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF DISTRICT ATTORNEY

SIGNATURE OF COUNTY CLERK

SIGNATURE OF CITY CLERK

SIGNATURE OF HEALTH COMMISSIONER

SIGNATURE OF HEALTH DEPARTMENT

SIGNATURE OF BALTIMORE CITY

SIGNATURE OF MARYLAND

SIGNATURE OF UNITED STATES

SIGNATURE OF WORLD

SIGNATURE OF FUTURE

SIGNATURE OF HISTORY

SIGNATURE OF LEGEND

SIGNATURE OF MAP

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SIGNATURE OF SURFACE

SIGNATURE OF VOLUME

SIGNATURE OF WEIGHT

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6406**

BIRTH NO.

1. NAME OF DECEASED **HELEN SCHWAB** 2. DATE OF DEATH **July 21, 1950**  
(Type or Print)

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION **1701 Eutaw Place**

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE **Maryland**  
C. CITY OR TOWN **Baltimore**  
D. STREET ADDRESS (If rural, give location) **1701 Eutaw Place**

Length of stay in Baltimore  
Yrs. Mos. Days

5. SEX **female** 6. COLOR OR RACE **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **is altered** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. **E981X** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) **Gunshot wound of head**

DUE TO

ANTECEDENT CAUSES (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) **home**

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **1701 Eutaw Place**

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY **July 21, 1950 9.00a.m.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? **firearms**

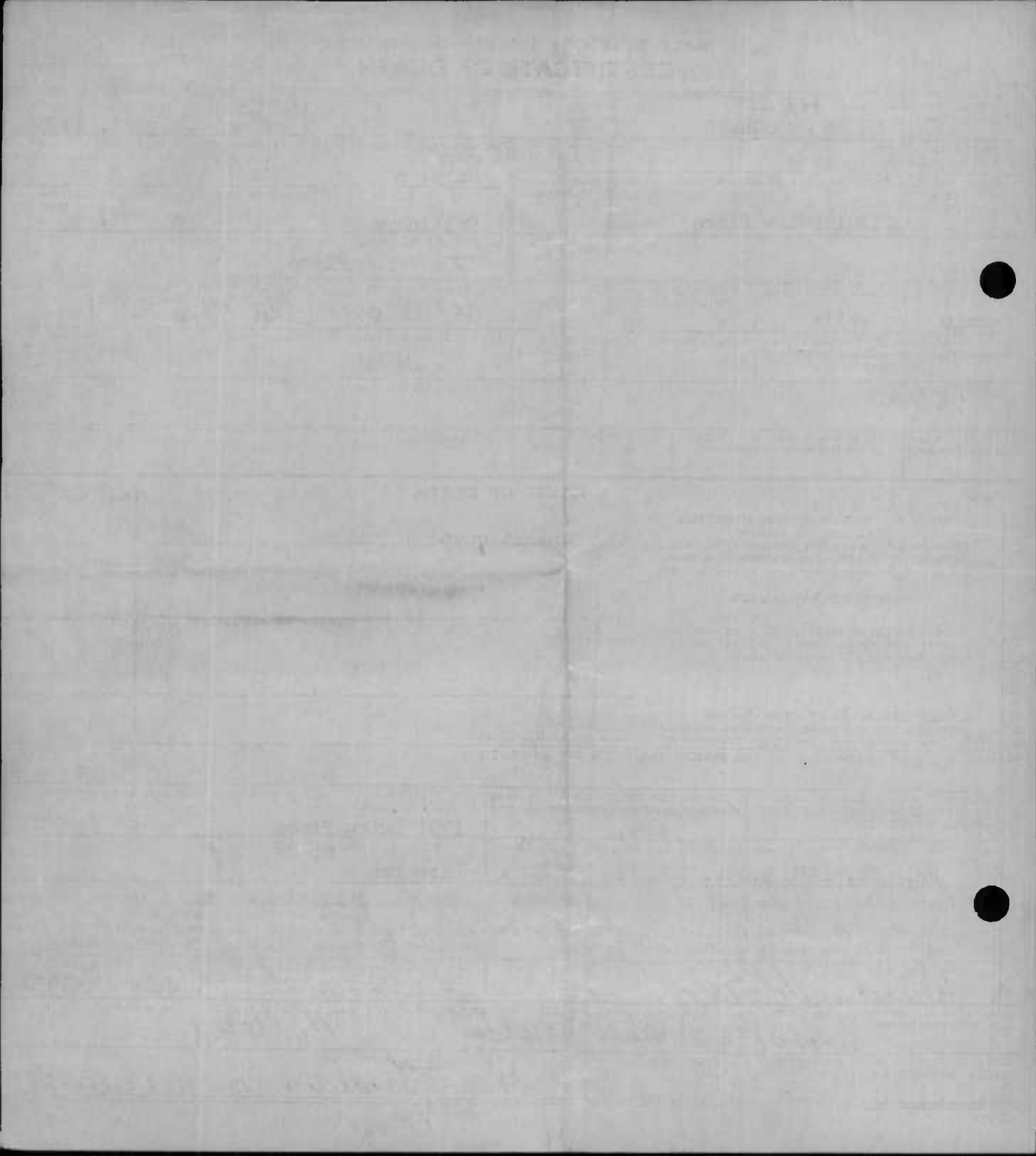
I certify that I took charge of the remains described above, held an **partial autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE **William V. Smith** 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ 23C. DATE SIGNED **July 21, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) **burial** 24B. DATE **July 23/50** 24C. NAME OF CEMETERY OR CREMATORY **Ches. Shalom** 24D. LOCATION (City, town, or county) (State) **Baltimore**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 22 1950** REGISTRAR'S SIGNATURE **Huntington Williams** 25. FUNERAL DIRECTOR **David Goodwin** ADDRESS **1902 Eutaw Rd**

VS 151 **N-8534** **166**





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6407  
Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>Louise Katherine Burkhardt</b>		2. DATE OF DEATH <b>July 19 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY _____			
B. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
D. STREET ADDRESS (If rural, give location) <b>3216 Ravenwood Ave</b>		E. LENGTH OF STAY IN BALTIMORE _____ Yrs. _____ Mos. _____ Days _____			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>		8. DATE OF BIRTH <b>Nov 18 1879</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Carl Barberich</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <b>Albert Burkhardt 5410 Hamlet Ave</b>	

18. <b>260X</b> <b>1</b> <b>157X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Diabetic Coma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7/14/50</b> <b>7/1/48</b> <b>8/5/49</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Carcinoma of Pancreas with metastasis to abdominal cavity</b>		

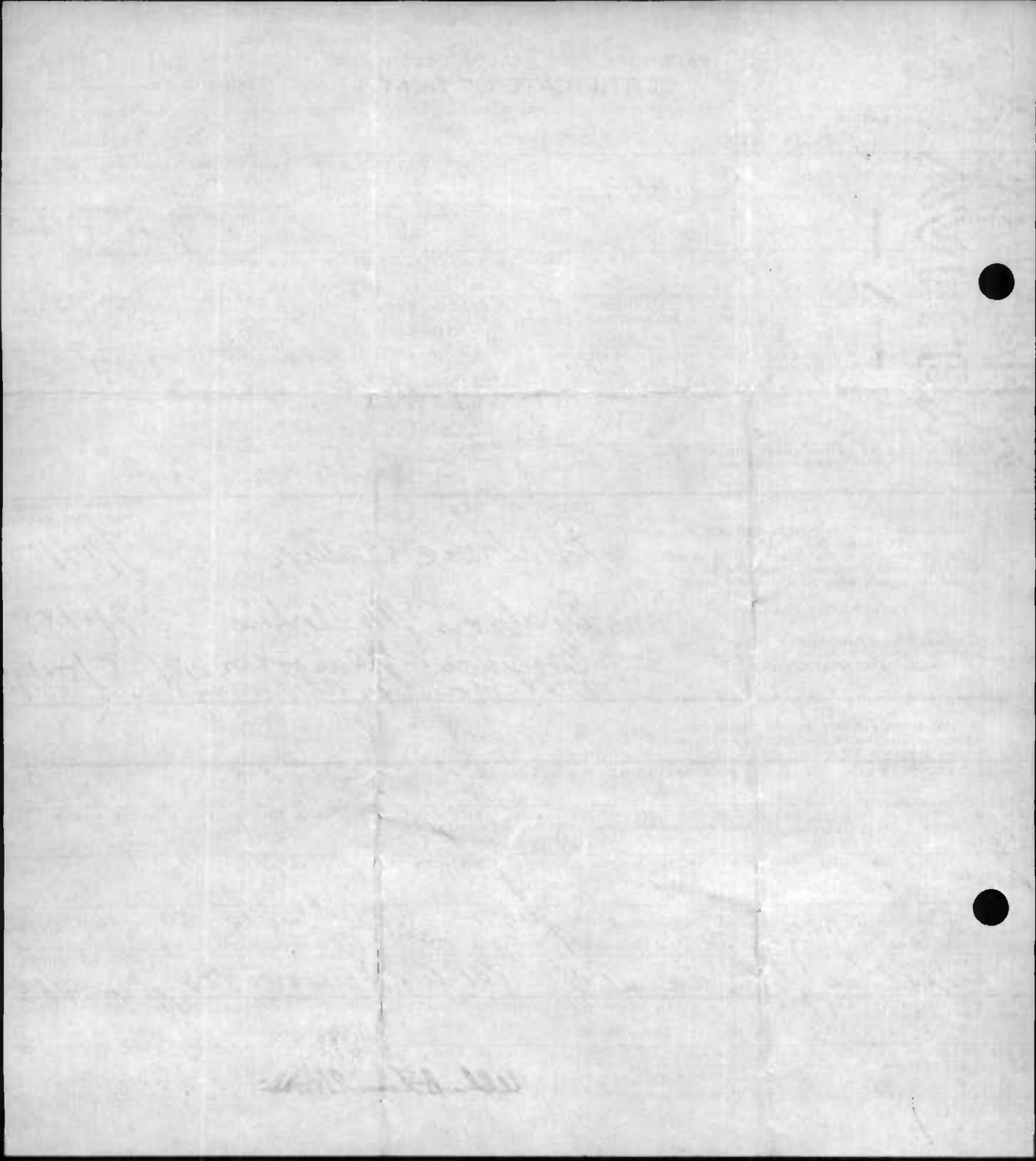
19A. DATE OF OPERATION _____		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	

I hereby certify that I attended the deceased from **July 1, 1948** to **July 19, 1950** that I last saw the deceased alive on **July 19, 1950** and that death occurred at **10:32 a.m.** from the causes and on the date stated above.

23A. SIGNATURE **William J. Byrner** M. D. 23B. ADDRESS **801 N. Newwood Av** 23C. DATE SIGNED **July 20/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **July 24 /50** 24C. NAME OF CEMETERY OR CREMATORY **Parkwood** 24D. LOCATION (City, town, or county) (State) **Baltimore**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 22 1950** REGISTRAR'S SIGNATURE **Thurston Williams, M.D.** 25. FUNERAL DIRECTOR ADDRESS **William H. Tamm, Inc. 2008 Orleans St**



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6408

Registered No.

BIRTH NO. 6408

1. NAME OF DECEASED (Type or Print) <b>HARRY J. West</b>		2. DATE OF DEATH <b>7-20-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
5. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>3129 Northway Drive</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-05</b>	
6. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>3129 Northway Drive</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Manager -</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>United Whelan</b>	
13. FATHER'S NAME <b>Columbus West</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET Korber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes, no or unknown		16. SOCIAL SECURITY NO. <b>212-07-0786</b>	
17. INFORMANT ADDRESS <b>Mrs. Blanche E. West. 3129 Dr.</b>		12. CITIZEN OF WHAT COUNTRY?	

18. <b>443 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) <b>Acute Pulmonary Edema</b>		<b>1 hr</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) <b>Cardio-Vascular -</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.		(C) <b>Hypertensive Disease</b>		<b>4 yrs</b>	

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1946</b> , 19 <b>19</b> , to <b>7/20</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/20</b> , 19 <b>50</b> , and that death occurred at <b>11:45</b> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Harold C. Dodd M.D.</b>		23B. ADDRESS <b>2108 St Paul St</b>		23C. DATE SIGNED <b>7/21/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>		25. FUNERAL DIRECTOR <b>Leonard J. Ruck - 5305 Hartford</b>			

Dr. Homer Todd  
2108 ST. PAUL ST

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 6409

0 - 6409

BIRTH NO.

TOM C. VAN ARSDEL

1. NAME OF DECEASED  
(Type or Print)

Van Arsedale, Mr. Tom

2. DATE  
OF  
DEATH

22 July 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Kentucky V-15

B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Church Home + Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Louisville

c. Length of stay in Baltimore

10

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

454 E. Lee St.

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Oct. 6, 1908

9. AGE (In years  
last birthday)

41

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Budget Officer

10B. KIND OF BUSINESS OR  
INDUSTRYA.E.C., Sandia Industry  
Albuquerque, N. M.

11. BIRTHPLACE (State or foreign country)

New Mexico

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ernest Van Arsedale

14. MOTHER'S MAIDEN NAME

Farmer, Marion

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Katherine N. Van Arsdel, 454 E. Lee

18.

CAUSE OF DEATH

St., Louisville, Ky.

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO

Pulmonary Emphysema 5 yrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

Bronchiolar Asthma 5 yrs.

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial heart disease

19A. DATE OF OPERATION

July 17, 1950

19B. MAJOR FINDINGS OF OPERATION

Large emphysematous Bullae

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 13 July, 1950, to 22 July, 1950, that I last saw the  
deceased alive on 22 July, 1950, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 22 1950

Christington Williams, M.D.

John O. Mitchell, Esq., Entombr Place





C-462

CERTIFICATE CORRECTED

7-25-50

BALTIMORE CITY HEALTH DEPARTMENT

50

6410

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

50

6410

1. NAME OF DECEASED  
(Type or Print)

BURLIE (Burley) CLARK

2. DATE  
OF  
DEATH

July 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

17-02

D. STREET ADDRESS (If rural, give location)

536 W. Lanvale St.

C. Length of stay in Baltimore

30 yrs.

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Sept. 20, 1892

9. AGE (In years  
last birthday)

57

If Under 1 Year

Months: Days

If Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Restaurateur

10B. KIND OF BUSINESS OR  
INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

Reidsville, N. C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Annie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.I

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Rachel Clark, 623 Payson St. Balto,

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Carcinoma of the larynx

Metastatic Post radiation edema

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☒

23C. DATE SIGNED

July 22, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-27-50

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Reidsville, North Carolina

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

Charles F. Law - 802 Madison Ave

JUL 23 1950

2906M

47a V

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

(Date)

DECEASED

DATE

PLACE

CAUSE OF DEATH

DATE OF BIRTH

DATE OF DEATH

SIGNATURE

DATE

5-361  
50 6411

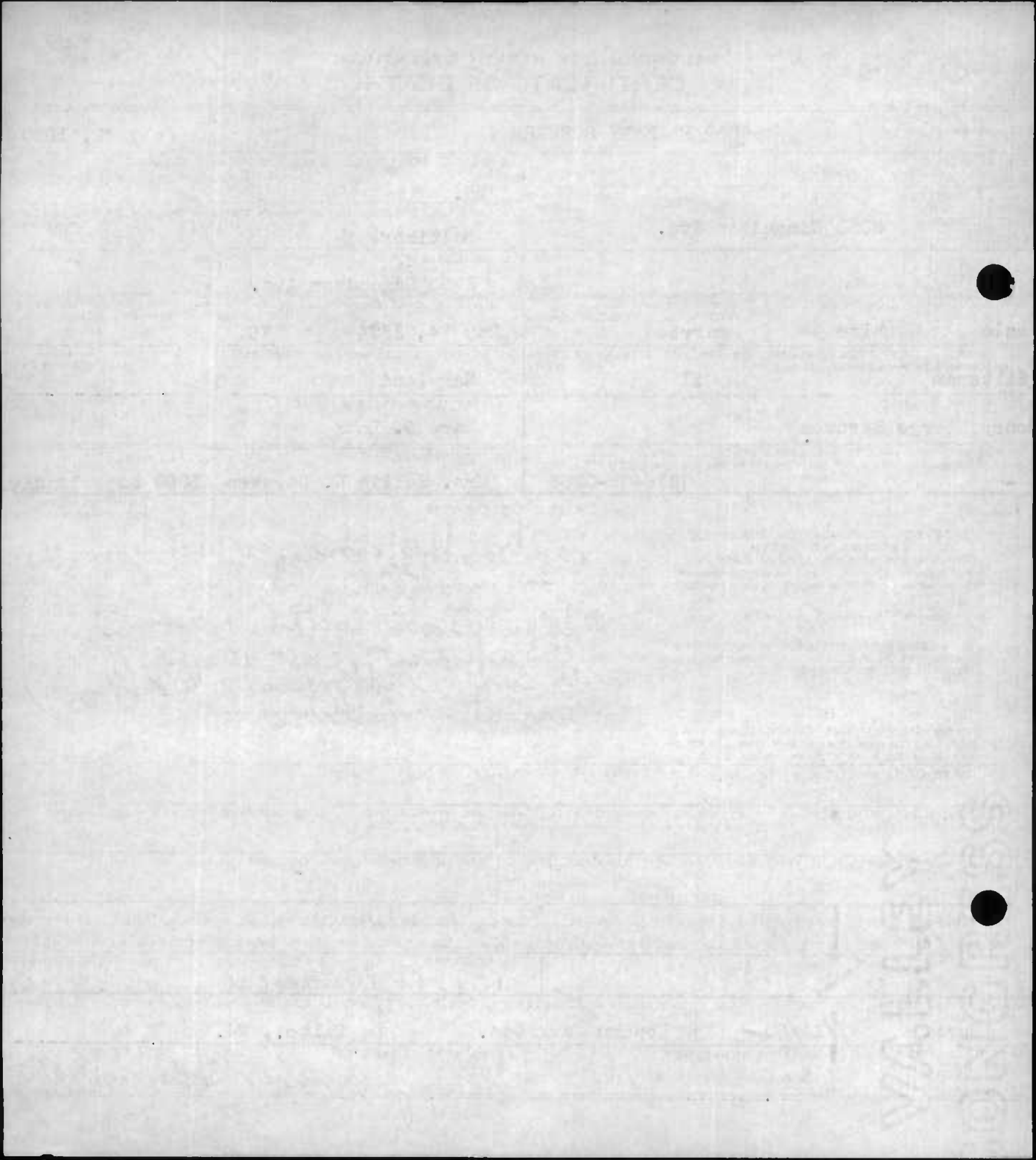
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6411  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
GEORGE HENRY STRUVEN			July 21, 1950		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
B. FULL NAME OF (If not in hospital or institution, give street address or location)			A. STATE Md.		
HOSPITAL OR INSTITUTION			B. COUNTY		
3050 Edmondson Ave.			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
D. STREET ADDRESS (If rural, give location)			Baltimore		
E. Length of stay in Baltimore			3050 Edmondson Ave.		
F. SEX			G. DATE OF BIRTH		
male			May 24, 1874		
H. COLOR OR RACE			I. AGE (In years last birthday)		
white			76		
J. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)			K. Under 1 Year		
married			Months: Days		
L. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			M. Under 24 Hours		
Salesman			Hours: Min.		
N. KIND OF BUSINESS OR INDUSTRY			O. BIRTHPLACE (State or foreign country)		
Oil			Maryland		
P. FATHER'S NAME			Q. CITIZEN OF WHAT COUNTRY?		
Henry George Struven			Mary G. Lotz		
R. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)			S. SOCIAL SECURITY NO.		
-			216-05-0255		
T. INFORMANT			U. ADDRESS		
Mrs. Sallie W. Struven			3050 Edmondson Ave.		

18. 420.0		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) Cerebral Hemorrhage with hemiplegia.		2 weeks.	
ANTECEDENT CAUSES		(B) Arteriosclerosis with hypertension.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) Arteriosclerotic type heart disease with cardiac enlargement and congestive failure.		(years)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
0				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
I hereby certify that I attended the deceased from May 1, 1950 to July 21, 1950 that I last saw the deceased alive on July 21, 1950, and that death occurred at 2 P. m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Dr. Michel		1015 Poplar Grove St		July 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		7/24/50		Loudon Park Cem.	
24D. LOCATION (City, town, or county)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Balto., Md.		Thos. J. Dickner & Sons		Balto. Md.	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR	
III 23 1950		Christington Williams, M.D.		Thos. J. Dickner & Sons	



5-221

50 6412

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

X 50 6412

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RAYMOND H. SHAKESPEARE.

2. DATE  
OF  
DEATH

7/22/50.

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Church Home &amp; Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md.

B. COUNTY

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

2974 Cornwall Rd.,

C. Length of stay in Baltimore

never 45 yrs.

5. SEX

Male.

6. COLOR OR RACE

White.

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married.

8. DATE OF BIRTH

6. 11. 1898.

9. AGE (In years  
last birthday)

52 yrs.

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Plumber.

10B. KIND OF BUSINESS OR  
INDUSTRY

Plumber.

11. BIRTHPLACE (State or foreign country)

Maryland.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HARRY SHAKESPEARE.

14. MOTHER'S MAIDEN NAME

MARGARET Haddaway

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

216-01-4759

17. INFORMANT

ADDRESS

Church Home &amp; Hospital

18. 330 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

DUE TO

Subarachnoid Hemorrhage.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

Hypertension.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 7. 21. 19 50. 7/22/19 50, that I last saw the deceased alive on 7/21/19 50, and that death occurred at 3.30 a.m., from the causes and on the date stated above.

23A. SIGNATURE

M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/25/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Richner &amp; Sons, Balto. Md.

JUL 23 1950

574 246 111

83a

MEDICAL CERTIFICATION

CENTRIFUGATION

1. The sample is placed in a centrifuge tube.

2. The centrifuge is set to the desired speed.

3. The centrifuge is allowed to run for a specified time.

4. The sample is removed from the centrifuge tube.

5. The sample is analyzed for the desired component.

6. The results are recorded and the process is repeated.

7. The centrifuge is cleaned and the sample is disposed of.

8. The centrifuge is stored in a safe place.

9. The centrifuge is used for the next sample.

10. The centrifuge is used for the next sample.

11. The centrifuge is used for the next sample.

12. The centrifuge is used for the next sample.

13. The centrifuge is used for the next sample.

14. The centrifuge is used for the next sample.

15. The centrifuge is used for the next sample.

16. The centrifuge is used for the next sample.

17. The centrifuge is used for the next sample.

18. The centrifuge is used for the next sample.

19. The centrifuge is used for the next sample.

20. The centrifuge is used for the next sample.

21. The centrifuge is used for the next sample.

22. The centrifuge is used for the next sample.

23. The centrifuge is used for the next sample.



B-420  
50 6413

50 6413

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TIEHIE BLOCK</b>		2. DATE OF DEATH <b>7-22-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md</b> B. COUNTY _____			
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>5809 Park Heights Ave</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-19</b>			
6. Length of stay in Baltimore <b>65</b> Yrs. <b>65</b> Mos. <b>65</b> Days		D. STREET ADDRESS (If rural, give location) <b>5809 Park Heights Ave</b>			
7. SEX <b>Female</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	10. DATE OF BIRTH <b>7-22</b>	11. AGE in years (day) <b>72</b>	12. If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Russel</b>		14. MOTHER'S MAIDEN NAME <b>Bora</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Harry J. Kassner</b> ADDRESS <b>Dume</b>	
18. <b>260X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Pulmonary edema</b> CAUSE OF DEATH (A) <b>Acute Pulmonary edema</b> DUE TO <b>Diabetes</b> (B) <b>Diabetes</b> DUE TO <b>Coronary Occlusion</b> (C) <b>Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 1/4 hr.</b> <b>?</b> <b>1 day</b>					
19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR? <b>5 PM</b>	
22. I hereby certify that I attended the deceased from <b>July 22, 1950</b> to <b>July 22, 1950</b> , that I last saw the deceased alive on <b>July 22, 1950</b> , and that death occurred at <b>5:30</b> p.m., from the causes and on the date stated above.					
23A. SIGNATURE <b>William E. Louna</b>		M. D. <b>4843 Park Heights Ave</b>		23C. DATE SIGNED <b>7/22/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>7-20-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New York N.Y.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 23 1950</b>		REGISTRAR'S SIGNATURE <b>William E. Louna</b>		25. FUNERAL DIRECTOR <b>Jack Lewicki</b> ADDRESS <b>2100 Eutan Rd</b>	

WATER RIGHTS

OF CALIFORNIA

WATER RIGHTS

OF CALIFORNIA

OF CALIFORNIA

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OF CALIFORNIA

B-652

50 6414

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6414  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FANNIE BURNSTEIN</b>		2. DATE OF DEATH <b>7-21-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>2476 Skirley ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY			
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mt Carmel Home</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
6. Length of stay in Baltimore <b>45</b>		D. STREET ADDRESS (If rural, give location) <b>1516 Washington St</b>			
7. SEX <b>Female</b>	8. COLOR OR RACE <b>White</b>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	10. DATE OF BIRTH <b>7/27</b>	11. AGE in years (at birthday) <b>74</b>	12. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
13. FATHER'S NAME <b>Rusker</b>		14. MOTHER'S MAIDEN NAME <b>Weyer</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Bernard Burnstein 2120 E Baltimore</b>	
18. <b>443 X I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>Cerebral hemorrhage - 6 weeks</b>			
ANTECEDENT CAUSES		(B) DUE TO <b>Hypertensive c.v.d.</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June-10-1950</b> to <b>July-21-1950</b> , that I last saw the deceased alive on <b>July-21-1950</b> , and that death occurred at <b>7:00</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. Herman Seidel</b>		23B. ADDRESS <b>2404 Eutan Pl</b>		23C. DATE SIGNED <b>7/22/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-23-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Mt Carmel</b>	
24D. LOCATION (City, town, or county) <b>Balto, Md</b>		24E. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>		24F. ADDRESS <b>2100 Eutan Pl</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 23 1950</b>		REGISTRAR'S SIGNATURE <b>William Williams, M.D.</b>			

Under  
2404 Canton PE

CERTIFICATE OF DEATH

W-350  
50 6415

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6415  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <i>Martha B Whitney</i>		2. DATE OF DEATH <i>July 21/1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>5206 Gwynn Oak Ave.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 25-02</i>	
6. LENGTH OF STAY IN BALTIMORE <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>5206 Gwynn Oak Ave.</i>	
7. SEX <i>Female</i>	8. COLOR OR RACE <i>White</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	10. DATE OF BIRTH <i>May 25/1872</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George H. Whitney</i>		14. MOTHER'S MAIDEN NAME <i>Jane Harrison</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mary H. Whitney</i>		ADDRESS <i>5206 Gwynn Oak Ave.</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>420.1 181.X</i>	CAUSE OF DEATH (A) <i>Coronary Occlusion</i> DUE TO (B) <i>Hypertension, Arteriosclerosis</i> DUE TO (C) <i>Carcinoma of bladder</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>? yrs.</i> <i>2 mos</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>to my knowledge</i>		

19A. DATE OF OPERATION <i>none</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
I hereby certify that I attended the deceased from <i>1940</i> , to <i>7/21/50</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7/20/50</i> , 19 <i>50</i> , and that death occurred at <i>11:55 AM</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>H. H. Harper</i>		23B. ADDRESS M. D. <i>5201 Gwynn Oak Ave.</i>		23C. DATE SIGNED <i>7/21/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 24/1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Baltimore Md</i>		24E. FUNERAL DIRECTOR <i>Harry H. H. H.</i>		ADDRESS <i>4204 Ridgewood Ave</i>	

ask physician, if  
Cancer or Heart  
condition, in his opinion,  
was probably cause underlying my  
death.



13-626  
50 6416

50 6416

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		John Louis Burucker		July 21 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 522 Random Road		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-31			
C. Length of stay in Baltimore 50 Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 522 Random Road			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH Jan 8 1871	9. AGE (in years last birthday) 79	10. Under 1 Year Months Days 11. Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer		10B. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Boat		11. BIRTHPLACE (State or foreign country) Sandy Hook Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME John Louis Burucker			
14. MOTHER'S MAIDEN NAME Alice M. Grumbine		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS M. Adele Pagels 522 Random Road			
18. 420.0 154X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Arteriosclerotic Heart Disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH unknown			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		(B) DUE TO			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO		(C) DUE TO			
21. DATE OF OPERATION June 10, 1950		22. MAJOR FINDINGS OF OPERATION Carcinoma of rectum		23. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
24. ACCIDENT, SUICIDE, HOMICIDE (Specify)		25. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		26. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
27. TIME (Month) (Day) (Year) (Hour) OF INJURY		28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
I hereby certify that I attended the deceased from June 10, 1950, to July 21, 1950, that I last saw the deceased alive on July 21, 1950, and that death occurred at 4:10 p. m., from the causes and on the date stated above.					
30. SIGNATURE J. J. Gava		31. ADDRESS 10 Malvern Hill Ave		32. DATE SIGNED July 22, 1950	
33. BURIAL, CREMATION, REMOVAL (Specify) Burial		34. DATE July 24 1950		35. NAME OF CEMETERY OR CREMATORY Mt. Olivet	
36. LOCATION (City, town or county) Baltimore Md		37. FUNERAL DIRECTOR ADDRESS Maurice C. Sykes 1600 W. North Ave			
38. DATE RECEIVED BY LOCAL REGISTRAR JUL 23 1950		39. REGISTRAR'S SIGNATURE Thurston Williams, M.D.			

467

Leo Goren 1 Mallon Hill Rd!

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6417  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

**Enoch N. Dorsey**

2. DATE  
OF  
DEATH

**July 21 1950**

3. PLACE OF DEATH:

A. Baltimore City, Maryland **1400 W. Lexington St.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
**Aged Women's & Aged Men's Homes**

C. Birth of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**  
B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
**Baltimore**

D. STREET ADDRESS (If rural, give location)  
**1400 W. Lexington St.**

5. SEX

**Male**

6. COLOR OR RACE

**White**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Widowed**

8. DATE OF BIRTH

**Oct. 24, 1863**

9. AGE (in years last birthday)

**86**

If Under 1 Year Months: Days Hours: Min.

**8 27**

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Ret.**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

**Elisha N. Dorsey**

14. MOTHER'S MAIDEN NAME

**Rose Cullings**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**L. H. Read 1400 W. Lexington St.**

18. **443X**

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Cerebral Hemorrhage**  
DUE TO

**48 hrs**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) **Hypertensive Arteriosclerotic Cardio-vascular disease**  
DUE TO  
(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

I hereby certify that I attended the deceased from **February, 1950** to **July 20, 1950**, that I last saw the deceased alive on **July 20, 1950**, and that death occurred at **2:30 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

**Newland Edward Day**

M. O.

**4-8-33rd St**

**July 22, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

**burial**

24B. DATE

**7/24/50**

24C. NAME OF CEMETERY OR CREMATORY

**Edlo**

24D. LOCATION (City, town or county) (State)

**Baltimore County, Maryland**

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

**Wilmington Williams, M.D.**

**Wm. Cook, Inc.**

**1217 St. Paul Street**

**JUL 24 1950**

**93D**

4 2.33rd

Dr. Janett

11 2 Chase

50  
50 6418

## CERTIFICATE CORRECTED

7-26-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 50 6418

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)WIER  
EDITH NEIR HORNE2. DATE  
OF  
DEATH

7/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

MARYLAND GENERAL HOSP

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. F W

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

13. FATHER'S NAME

ROBERT WIER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

2/4-22-0196

8. DATE OF BIRTH

4-29-73

9. AGE (in years  
last birthday)

77

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

14. MOTHER'S MAIDEN NAME

? Sarah F. Cushing

17. INFORMANT

ADDRESS

Patient

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic cardiovascular disease 10 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT ☐NOT WHILE ☐

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 7/21, 1950 to 7/21, 1950, that I last saw the deceased alive on 7/21, 1950, and that death occurred at 4P m., from the causes and on the date stated above.

23A. SIGNATURE

Paul G. Herold

M. D.

23B. ADDRESS

Maryland

23C. DATE SIGNED

7/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-25-50

24C. NAME OF CEMETERY OR CREMATORY

GREENMOUNT

24D. LOCATION (City, town, or county)

BALTIMORE, MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

W. Cook, Inc. 1217 St. Paul St.





630  
50 6419

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6419  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Clara R. Short

2. DATE  
OF  
DEATH

July 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

334 East 25th Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore

D. STREET ADDRESS (If rural, give location)  
334 East 25th Street

5. LENGTH OF STAY IN BALTIMORE

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 21, 1886

9. AGE (In years last birthday)

64

10. Under 1 Year  
Months: Days

11. Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Stewart & Company

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

William H. C. Roe

14. MOTHER'S MAIDEN NAME

Clara M. Raybold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Henry C. R. Short, 3013 Frisby St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO

74 hypertension  
arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

Coronary Thrombosis

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

I hereby certify that I attended the deceased from Jan 1, 1946, to July 22, 1950, that I last saw the deceased alive on July 22, 1950, and that death occurred at 2 A. M., from the causes and on the date stated above.

23A. SIGNATURE  
Dr. Eph. H. Hahn

23B. ADDRESS  
M. O. 443 E 25th St

23C. DATE SIGNED  
July 22, 1950

24A. BURIAL, CREMATION, REMOVAL (Specify)

burial

24B. DATE

7/25/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county) (State)

Baltimore,

Maryland

DATE RECEIVED BY LOCAL REGISTRAR

JUL 24 1950

REGISTRAR'S SIGNATURE

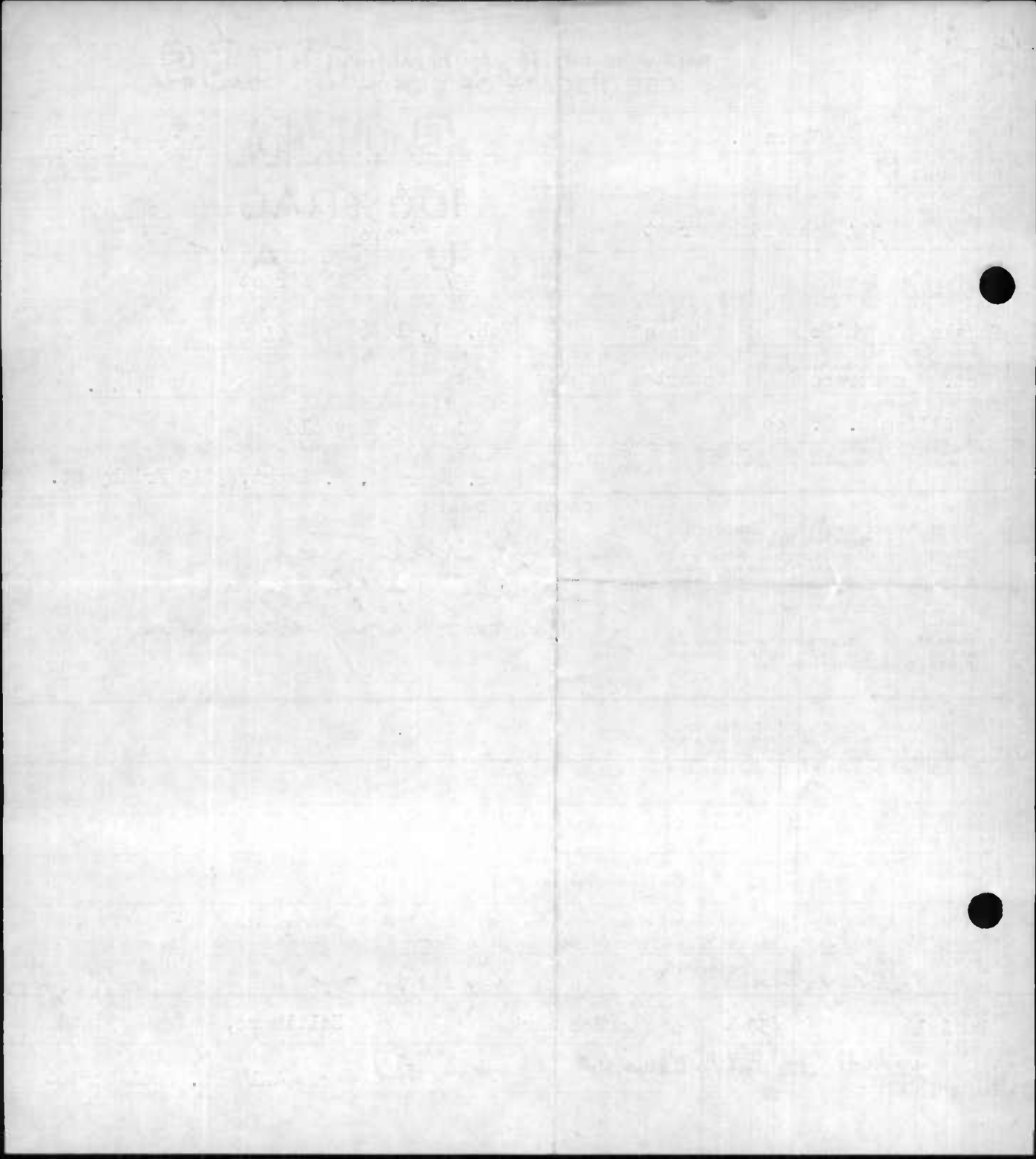
Huntington Williams, M.D.

25. FUNERAL DIRECTOR

Wm. Cook, Inc.

ADDRESS

1217 St. Paul Street



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6420

1. NAME OF DECEASED (Type or Print) <b>GEORGE W. CLOUGH</b>			2. DATE OF DEATH <b>July 21, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21-01</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <b>724 W. Cross Street</b>		
5. <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>April 23, 1886</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ASTON RING CO.</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNKNOWN</b>
13. FATHER'S NAME <b>CHANEY CLOUGH</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>MR. GEORGE L. CLOUGH 724 W. CROSS ST.</b>		

18. <b>4201</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary artery sclerosis</b> DUE TO <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>		CAUSE OF DEATH <b>Coronary artery sclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH
---	--	--	----------------------------------

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK			

I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>Stanley H. Dunleavy</b>	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D.	23C. DATE SIGNED <b>July 21, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>7/25/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE CEM.</b>
24D. LOCATION (City, town, or county) (State) <b>STEVENSVILLE, MD.</b>	25. FUNERAL DIRECTOR ADDRESS <b>JOHN F. DENNY, Inc. 715 LIGHT ST.</b>	
DATE RECEIVED BY LOCAL REGISTRY <b>JUL 24 1950</b>		

REPUBLIC OF THE PHILIPPINES  
DEPARTMENT OF HEALTH  
BUREAU OF PREVENTIVE MEDICINE  
OFFICE OF THE ASSISTANT SECRETARY  
CERTIFICATE OF DEATH

2 Name

1. Name of Deceased		2. Sex		3. Age		4. Date of Death	
5. Cause of Death		6. Place of Death		7. Signature of Physician		8. Signature of Registrar	
9. Signature of Informant		10. Signature of Informant		11. Signature of Informant		12. Signature of Informant	
13. Signature of Informant		14. Signature of Informant		15. Signature of Informant		16. Signature of Informant	
17. Signature of Informant		18. Signature of Informant		19. Signature of Informant		20. Signature of Informant	
21. Signature of Informant		22. Signature of Informant		23. Signature of Informant		24. Signature of Informant	
25. Signature of Informant		26. Signature of Informant		27. Signature of Informant		28. Signature of Informant	
29. Signature of Informant		30. Signature of Informant		31. Signature of Informant		32. Signature of Informant	
33. Signature of Informant		34. Signature of Informant		35. Signature of Informant		36. Signature of Informant	
37. Signature of Informant		38. Signature of Informant		39. Signature of Informant		40. Signature of Informant	
41. Signature of Informant		42. Signature of Informant		43. Signature of Informant		44. Signature of Informant	
45. Signature of Informant		46. Signature of Informant		47. Signature of Informant		48. Signature of Informant	
49. Signature of Informant		50. Signature of Informant		51. Signature of Informant		52. Signature of Informant	
53. Signature of Informant		54. Signature of Informant		55. Signature of Informant		56. Signature of Informant	
57. Signature of Informant		58. Signature of Informant		59. Signature of Informant		60. Signature of Informant	
61. Signature of Informant		62. Signature of Informant		63. Signature of Informant		64. Signature of Informant	
65. Signature of Informant		66. Signature of Informant		67. Signature of Informant		68. Signature of Informant	
69. Signature of Informant		70. Signature of Informant		71. Signature of Informant		72. Signature of Informant	
73. Signature of Informant		74. Signature of Informant		75. Signature of Informant		76. Signature of Informant	
77. Signature of Informant		78. Signature of Informant		79. Signature of Informant		80. Signature of Informant	
81. Signature of Informant		82. Signature of Informant		83. Signature of Informant		84. Signature of Informant	
85. Signature of Informant		86. Signature of Informant		87. Signature of Informant		88. Signature of Informant	
89. Signature of Informant		90. Signature of Informant		91. Signature of Informant		92. Signature of Informant	
93. Signature of Informant		94. Signature of Informant		95. Signature of Informant		96. Signature of Informant	
97. Signature of Informant		98. Signature of Informant		99. Signature of Informant		100. Signature of Informant	

51

TRUMBO

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6421

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Sophia Elizabeth Trumbo

2. DATE  
OF  
DEATH

7-20-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Lutheran Hospital of Maryland

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)  
MARRIED

8. DATE OF BIRTH

OCTOBER 3, 1878

9. AGE (In years,  
last birthday)

72

10. Under 1 Year  
Months Days  
11. Under 24 Hours  
Hours Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSE WIFE

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

WARNER.

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

MR. ANDREW J. TRUMBO 411 PUPAR GROVE ST.

18. 420.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cardiac Tamponade

DUE TO

7 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Myocardial Rupture

DUE TO

(C) Posterior Myocardial Infarction

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from July 13, 1950, to July 20, 1950, that I last saw the deceased alive on July 20, 1950, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Muriel S. Daly

23B. ADDRESS

M. D. Lutheran Hosp of Md.

23C. DATE SIGNED

7-21-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

7/24/50

24C. NAME OF CEMETERY OR CREMATORY

CEDAR HILL

24D. LOCATION (City, town, or county)

RITCHIE HIGGAWAY

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC 715 LIGHT ST.

2 Copies



615  
0 6422BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6422

1. NAME OF DECEASED (Type or Print) Dora Victoria Urbanski		2. DATE OF DEATH July 22-1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland 701 S.Wolfe Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION Daughters)Home(		C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 2-03	
C. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 709 S.Wolfe Street	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH May ? 1870
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 80
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?? Rybarczyk		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Catherine Farren 218 S.Washington Street		ADDRESS	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Chronic Hypertensive Cardiovascular Disease Anterolateral - Semilethal - Degenerative	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
I hereby certify that I attended the deceased from Jan 1950 to July 1950, that I last saw the deceased alive on July 22, 1950, and that death occurred at 6:55 A.M., from the causes and on the date stated above.					
23A. SIGNATURE Huntington J. Williams, M.D.		23B. ADDRESS 2711 Carter Ave.		23C. DATE SIGNED July 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/26/50.		24C. NAME OF CEMETERY OR REPOSITORY St. Stanislaus	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. FUNERAL DIRECTOR George A. Weber 705 S. Ann Street.		24F. ADDRESS	

1. The first of these is the fact that the  
 2. second of these is the fact that the  
 3. third of these is the fact that the  
 4. fourth of these is the fact that the  
 5. fifth of these is the fact that the

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6423**

**BIRTH NO.** **6423**

1. NAME OF DECEASED (Type or Print) <b>MARIAM KEVIN</b>		2. DATE OF DEATH <b>7-23-50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>1300 Mosker St</b>		C. CITY OR TOWN (If outside corporate limits, write R.R. and give township) <b>Baltimore 16-02</b>	
C. Length of stay in Baltimore <b>50</b> Yrs. <del>Mo.</del> <del>Days</del>		D. STREET ADDRESS (If rural, give location) <b>1300 Mosker St</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>90</b>
9. AGE (in years last birthday) <b>90</b>		10. UNDER 1 Year Months: Days	11. UNDER 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Abraham</b>		14. MOTHER'S MAIDEN NAME <b>Daily</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Abraham Kevin</b>		ADDRESS <b>same</b>	

<p>18. <b>331X</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH <b>Central vascular accident</b></p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</p> <p><b>Generalized arterio-sclerosis 15 years</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>	<p>(A) <b>Central vascular accident</b></p> <p>DUE TO</p> <p>(B) <b>Generalized arterio-sclerosis 15 years</b></p> <p>DUE TO</p> <p>(C)</p>

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>I hereby certify that I attended the deceased from <b>May 20 1950</b>, to <b>July 22, 1950</b>, that I last saw the deceased alive on <b>7/22/1950</b>, and that death occurred at <b>6:47 m.</b>, from the causes and on the date stated above.</p>					
23A. SIGNATURE <b>Jack Cohen</b>		23B. ADDRESS <b>1804 Centaur Place</b>		23C. DATE SIGNED <b>7/23/50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Hebrew Mt Carmel</b>	
24D. LOCATION (City, town, or county) <b>Balto</b>		24E. STATE <b>Md</b>			
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, MD</b>		25. FUNERAL DIRECTOR <b>Jack Lewis Inc</b>	
				ADDRESS <b>2100 Centaur Pl</b>	

J. Cohen  
1804  
Beetard 92

000

Joh

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6424

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Annie Alley Joh

2. DATE  
OF  
DEATH

7/21/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

The Hospital for the Women Maryland

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

30 yrs.

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Hospital Womens

13. FATHER'S NAME

George Cookman Dukes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Eva Joh

ADDRESS

5008 Frederick Ave

18. 443X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Occident - hemorrhage

7 hrs.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Disease

?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/21/50, 19\_\_, to 7/21/50, 19\_\_, that I last saw the deceased alive on 7/21, 1950, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Mark S. Holt

23B. ADDRESS

Women's Hospital

23C. DATE SIGNED

7/21/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1950

Wilmington Williams, MD

Harry H. Hutz

4101 Edmondson Ave.

MEDICAL CERTIFICATION

STATE OF NEW YORK  
CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Occupation		Residence	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	



240  
50 6425BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6425  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>ROMEO CHESLEY</b>		2. DATE OF DEATH <b>July 20, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>11-03</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Maryland General Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>865 Linden Avenue</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>3-5-1905</b>
9. AGE (in years last birthday) <b>45</b>		10. UNDER 1 Year Months Days 11. UNDER 24 Hours Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dishwasher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Caterer</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Wm. H. James Chesley</b>		14. MOTHER'S MAIDEN NAME <b>Florence Wilson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Coast Guard</b>	
17. INFORMANT <b>Mary Chesley</b>		ADDRESS <b>865 Linden Ave</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Far advanced pulmonary tuberculosis</b> DUE TO (A) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an <u>Inquiry &amp; Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE <b>William V. Smith</b>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. MEDICAL INVESTIGATOR <input checked="" type="checkbox"/>	
23C. DATE SIGNED <b>July 20, 1950</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Frederick Ave</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Joseph S. Rock, Jr.</b>		ADDRESS <b>1304 N. Central</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form No. 1

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15 1880</i></p>	
<p>5. Place of birth: <i>New York City</i></p>		<p>6. Usual residence: <i>123 Main St, Wash DC</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Date of death: <i>Dec 10 1925</i></p>	
<p>9. Time of death: <i>10:30 AM</i></p>		<p>10. Place of death: <i>Home</i></p>	
<p>11. Signature of physician: <i>J. Smith</i></p>		<p>12. Signature of registrar: <i>M. Jones</i></p>	
<p>13. Signature of informant: <i>W. Brown</i></p>		<p>14. Date of filing: <i>Dec 12 1925</i></p>	

650

50

REA-136424

6426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

6426

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE  
B. COUNTY

5. FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

6. LENGTH OF STAY IN BALTIMORE  
Yrs.  
Mos.  
Days

7. SEX  
Female

8. COLOR OR RACE  
Negro

9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Separated

10. DATE OF BIRTH  
May 10, 1888

11. AGE (In years last birthday)  
62

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME  
Alexander Martin

14. MOTHER'S MAIDEN NAME  
Carrie Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT  
Records: B. C. H. 4940 Eastern Ave.

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  
CAUSE OF DEATH  
Interval between onset and death

19. DATE OF OPERATION

20. AUTOPSY?  
YES ☒ NO ☐

21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

22. I hereby certify that I attended the deceased from 3-8, 1950, to 7-21, 1950, that I last saw the deceased alive on 7-21, 1950, and that death occurred at 10P m., from the causes and on the date stated above.

23. SIGNATURE  
M. D.

24. ADDRESS  
4940 Eastern Avenue

25. DATE SIGNED  
7-22-50

26. BURIAL, CREMATION, REMOVAL (Specify)

27. DATE

28. NAME OF CEMETERY OR CREMATORY

29. LOCATION (City, town, or county) (State)

30. DATE RECEIVED BY LOCAL REGISTRAR

31. REGISTRAR'S SIGNATURE

32. FUNERAL DIRECTOR

33. ADDRESS

VS 150

136

Military Title of Langs 2

"of Langs" from Bureau of Tabulation records

2

7-10-50

ES

-250

6427

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6427  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>George Jackson</b>		2. DATE OF DEATH <b>JUL 22 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Bu 2-400</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>Baltimore</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>1700 Northern Pkwy</b>		E. DATE OF BIRTH <b>11-9-89</b>	
F. AGE (In years last birthday) <b>60</b>		G. Under 1 Year Months: Days <b>60</b>	
H. Under 24 Hours Hours: Min. <b>60</b>		I. BIRTHPLACE (State or foreign country) <b>Calvert Co., Md.</b>	
J. CITIZEN OF WHAT COUNTRY? <b>U.S.-A</b>		K. MOTHER'S MAIDEN NAME <b>ELIZEBETH ?</b>	
L. FATHER'S NAME <b>SAMUEL JACKSON</b>		M. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
N. SOCIAL SECURITY NO.		O. INFORMANT ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>	

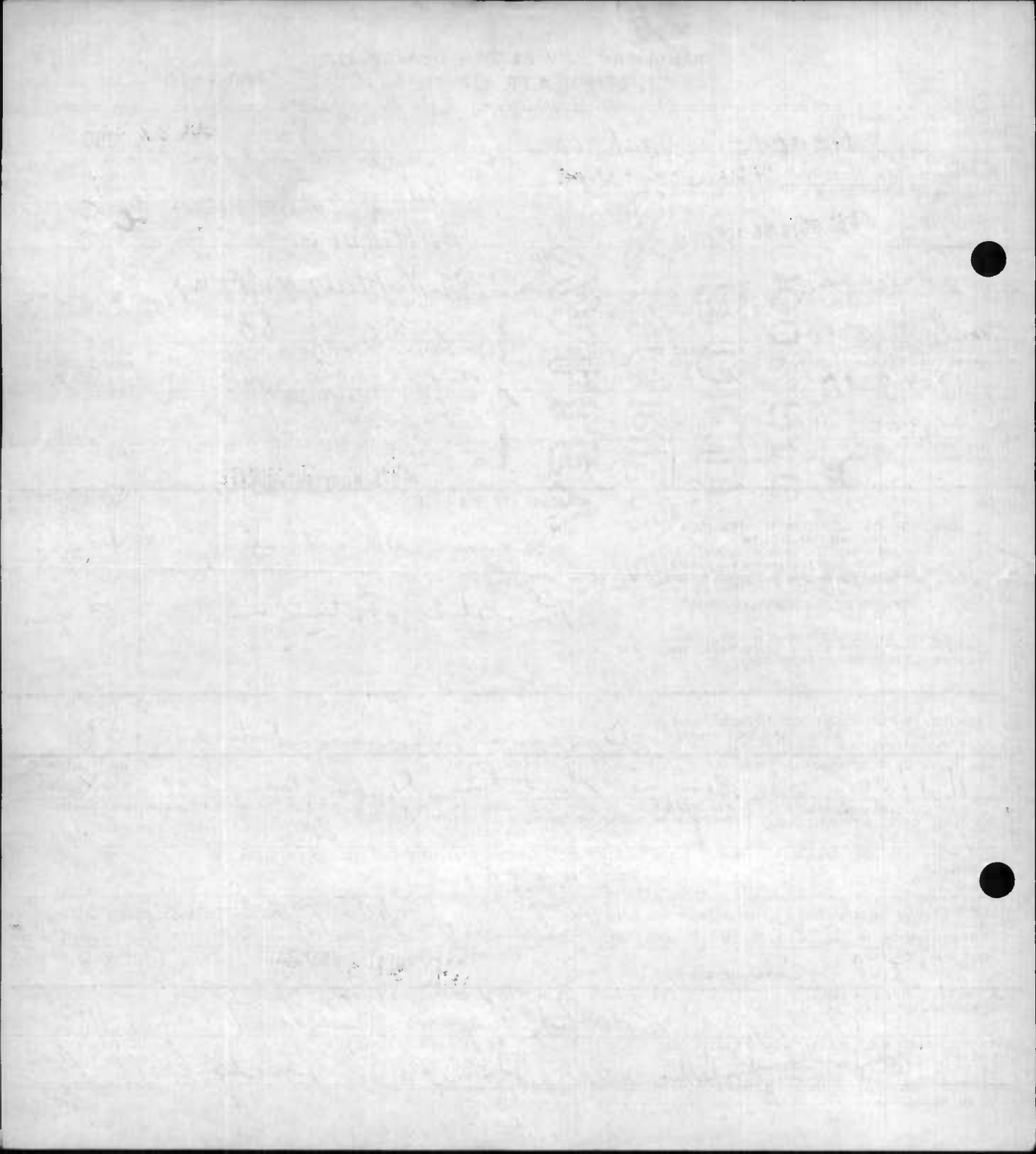
18. <b>610X 180X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b> DUE TO <b>Prostatic obstruction.</b> DUE TO <b>?</b>	CAUSE OF DEATH <b>JOHNS HOPKINS HOSPITAL</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 day?</b> <b>3 yrs</b> <b>?</b>
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19A. DATE OF OPERATION <b>7/21/50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Benign Prostatic Hyperplasia</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Carcinoma involving Kidneys</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>7-22-1950</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-18-1950** to **7-22-1950**, that I last saw the deceased alive on **7-22-1950**, and that death occurred at **7:00 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Paul H. Surace</b>		23B. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>		23C. DATE SIGNED <b>7-22-50</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>7/27/50</b>		24B. DATE <b>7/27/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Brook's Chapel</b>
24D. LOCATION (City, town, or county) (State) <b>Calvert Co., Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>
24G. FUNERAL DIRECTOR <b>Joseph A. Lively</b>		24H. ADDRESS <b>661 W. Barr</b>		24I. VS 150

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6428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 6428

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) *annie Johnson*

2. DATE OF DEATH *7-19-1950*

3. PLACE OF DEATH:  
A. Baltimore City, Maryland *923 N. Gay St*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE *Maryland*  
B. COUNTY *Baltimore*

5. SEX *Male*

6. COLOR OR RACE *Colored*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) *Widowed*

8. DATE OF BIRTH *8-19-1887*

9. AGE (in years last birthday) *62*

10. UNDER 1 Year Months: Days *11*

11. UNDER 24 Hours Hours: Min. *11*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Unknown*

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) *Baltimore County Md*

12. CITIZEN OF WHAT COUNTRY? *U.S.A.*

13. FATHER'S NAME *Charles Thomas*

14. MOTHER'S MAIDEN NAME *Unknown*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) *No*

16. SOCIAL SECURITY NO.

17. INFORMANT *Charles Thomas*

ADDRESS *923 N Gay St*

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) *Uremia*

CAUSE OF DEATH *Intestinal reflux*

INTERVAL BETWEEN ONSET AND DEATH *2 days*

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION *0*

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH ☐

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *7.17.1950* to *7.19.1950* that I last saw the deceased alive on *7.19.1950* and that death occurred at *9:50 p.m.* from the causes and on the date stated above.

23A. SIGNATURE *Wm. L. Roy Surry M.O.*

23B. ADDRESS *1420 E. Chase*

23C. DATE SIGNED *7.21.50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE *7/24/50*

24C. NAME OF CEMETERY OR CREMATORY *Mt. Calvary*

24D. LOCATION (City, town, or county) (State) *Arundel Co., Md.*

DATE RECEIVED BY LOCAL REGISTRAR *JUL 24 1950*

REGISTRAR'S SIGNATURE *Huntington Williams, M.D.*

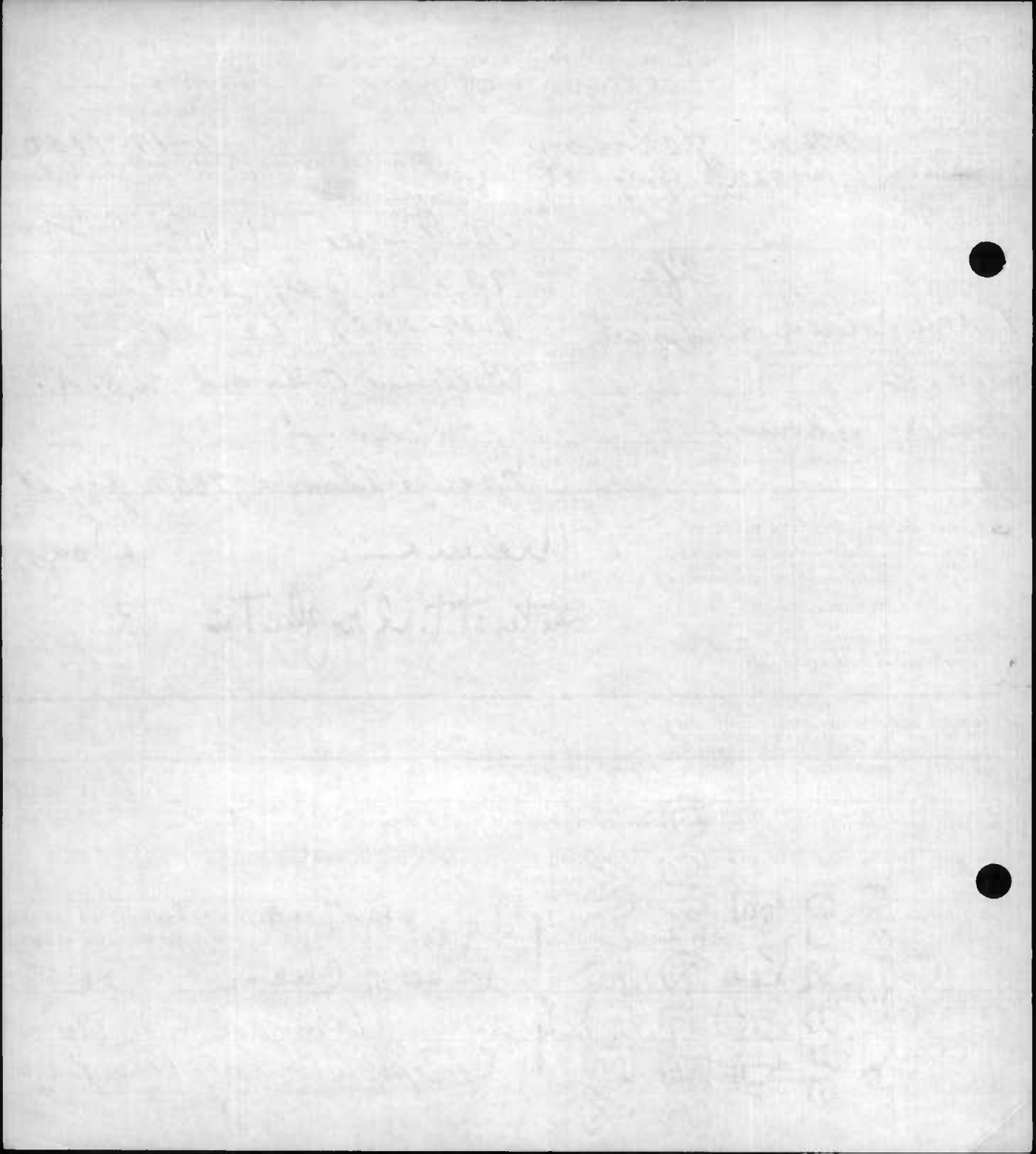
25. FUNERAL DIRECTOR *Joseph A. Lively*

ADDRESS *661 W. Barre St.*

VS 150

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562  
0 6429BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6429

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MARGARET R. LAUMERS

2. DATE  
OF  
DEATH

JULY 20, 1950.

3. PLACE OF DEATH:

A. Baltimore City, Maryland 380.8 HUDSON ST.

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION (If not in hospital or institution, give street address or  
location)4. USUAL RESIDENCE (Where deceased lived, If institution: residence  
before admission)

A. STATE

MD.

B. COUNTY

(If outside corporate limits, give RURAL and give  
township)

C. CITY OR TOWN

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3808 HUDSON ST.

c. Length of stay in Baltimore

ABOUT 50

Yrs.  
Mos.  
Days

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOWED

8. DATE OF BIRTH

APR. 9, 1883

9. AGE (In years  
last birthday)

67

10 Under 1 Year

Months: Days

11 Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

HOUSE WORK

10B. KIND OF BUSINESS OR  
INDUSTRY

AT HOME

11. BIRTHPLACE (State or foreign country)

GERMANY

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

? SCHIFFLER

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown)16. SOCIAL  
SECURITY NO.  
NONE

17. INFORMANT

ADDRESS

MRS. EILERT LAW 3808 HUDSON ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) .....  
DUE TO

Arteriosclerosis C.V. Disease Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) .....  
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C) .....

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT ☐  
WORKNOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-19, 1950, to 7-20, 1950, that I last saw the  
deceased alive on 7-20, 1950, and that death occurred at 9 P.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

BURIAL

JULY 24, 1950

OAK LAWN CEM.

7225 EASTERN AVE., MD.

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25 FUNERAL DIRECTOR

ADDRESS

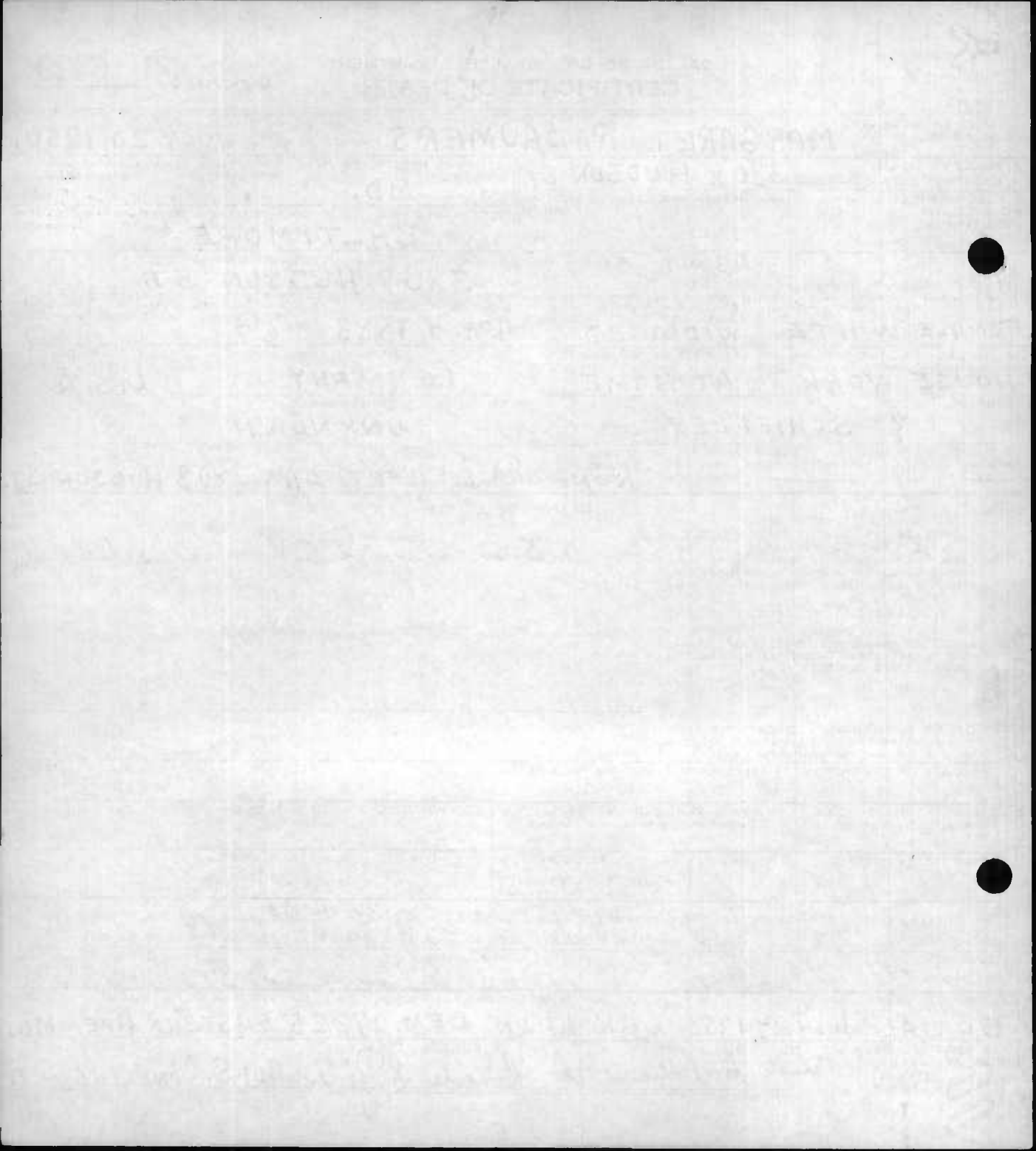
Huntington Williams, M.D.

Charles S. Ziller 901 S. CONKLING ST.

JUL 24 1950

VS 150

93D



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6430  
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>William SHERMAN HEISS</b>		2. DATE OF DEATH <b>July 21, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
D. STREET ADDRESS (If rural, give location) <b>1506 N. Montford Street</b>		E. LENGTH OF STAY IN BALTIMORE Yrs. _____ Mos. _____ Days _____	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED; DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>March-5-1895</b>
9. AGE (In years; last birthday) <b>55</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William Heiss</b>	
14. MOTHER'S MAIDEN NAME <b>Annie E. Betts</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Minnie Heiss - 1506 N. Montford Ave</b>	

18. <b>470.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	<b>CAUSE OF DEATH</b>  (A) <b>Coronary artery sclerosis</b> DUE TO  (B) <b>Myocardial infarct</b> DUE TO  (C) <b>Hypertensive cardiovascular disease</b>  INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>William H. [Signature]</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 21, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>North Ave - Balto Md.</b>		24E. FUNERAL DIRECTOR <b>John C. Miller, Inc. 2435 E. Oliver St</b>		24F. ADDRESS	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>Thurston Williams, M.D.</b>		342 4K	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF CLERK IN CHARGE	



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50 6431BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6431

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Agnes W. Maher</i>		2. DATE OF DEATH <i>July 22<sup>nd</sup> 1950</i>	
3. PLACE OF DEATH A. Baltimore City, Maryland <i>1305 Harford Ave</i>		4. USUAL RESIDENCE (Where deceased lived in institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9-09</i>			
B. FULL NAME OF HOSPITAL OR INSTITUTION —		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i>			
C. Length of stay in Baltimore <i>50</i>		D. STREET ADDRESS (If rural, give location) <i>1305 Harford Ave</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept 15 1874</i>	9. AGE (in years last birthday) <i>75 yrs</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Patrick Loney</i>		14. MOTHER'S MAIDEN NAME <i>Mary Maguire</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Peter J. Maher</i>	
18. <i>442X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic (arteriovascular) renal disease.</i>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>7</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April 25, 1950</i> , to <i>July 22, 1950</i> , that I last saw the deceased alive on <i>July 21, 1950</i> , and that death occurred at <i>6 A</i> m., from the causes and on the date stated above.					
23A. SIGNATURE <i>Joseph S. Plun M.D.</i>		23B. ADDRESS <i>1115 N. Calvert St</i>		23C. DATE SIGNED <i>7/24/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 25 1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Leatherside</i>	
24D. LOCATION (City, town, or county) <i>Fredrick Road</i>		25. FUNERAL DIRECTOR <i>Leo S. Brook 1701-03 N. Patterson Park</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 24 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>		ADDRESS <i>131a</i>	

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6432BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6432

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Bettie, Wise</b>		2. DATE OF DEATH <b>July 21-1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b> 4940 Eastern Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>14-02</b>			
C. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>565 Laurens St.</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>? 1869</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Year Months: Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>(D)</b>		14. MOTHER'S MAIDEN NAME <b>(D)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Records B.C.H.</b> ADDRESS <b>4940 Eastern Ave.</b>	
18. <b>470.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Arteriosclerotic Heart Disease</b> DUE TO ANTECEDENT CAUSES (B) <b>Generalized Arteriosclerosis</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>10-24-1949</b> to <b>7-21-1950</b> , that I last saw the deceased alive on <b>7-21-1950</b> and that death occurred at <b>8:00 AM</b> from the causes and on the date stated above.					
23A. SIGNATURE <b>[Signature]</b> M. D.		23B. ADDRESS <b>4940 Eastern Ave</b>		23C. DATE SIGNED <b>7-22-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7-24-50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. (State) <b>MD</b>		24F. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>	
24G. REGISTRAR'S SIGNATURE <b>Thurston Williams</b>		24H. FUNERAL DIRECTOR <b>W. A. ...</b>		24I. ADDRESS <b>3700 ...</b>	

MEDICAL CERTIFICATION

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6433BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6433

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John Williams

2. DATE  
OF  
DEATH

7/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

St. Joseph's

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR  
INDUSTRY

Factory

13. FATHER'S NAME

John W. Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Bessie Williams 1112 Etting St

18. 4721

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Anterior poliomyelitis C. v. disease

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

P. P. Lubinski

M.D.

23B. CHIEF MEDICAL EXAMINER.....☐  
ASSISTANT MEDICAL EXAMINER.....☐  
MEDICAL INVESTIGATOR.....☐

23C. DATE SIGNED

7/22/50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1950

Huntington Williams, M.D.

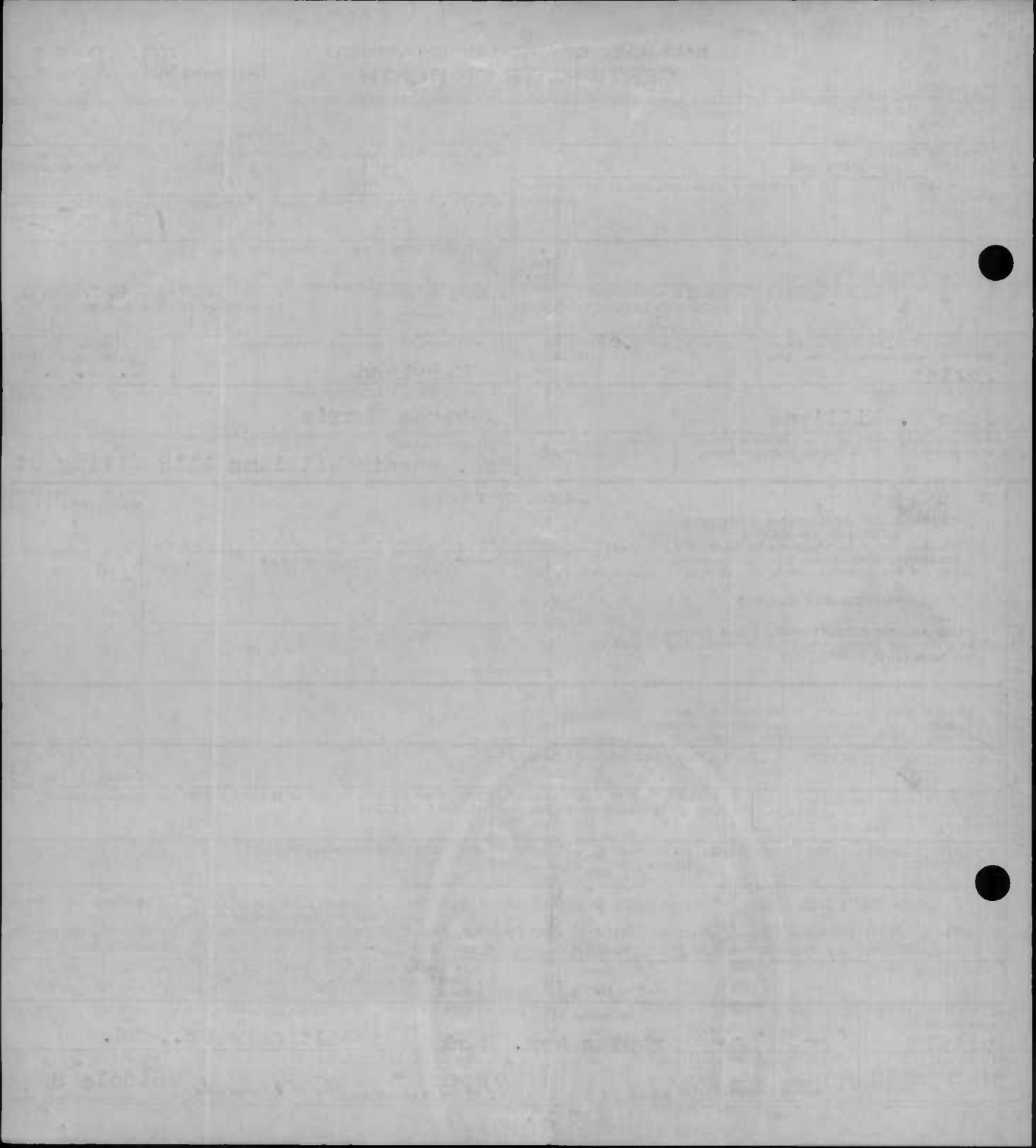
Mrs. Frances G. Hemmley

Biddle St

VS 151

78044 132

93D





463

6434

LEONA POLLARD  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6434

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Leona Pollard

2. DATE  
OF  
DEATH

July 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

B. COUNTY

B. FULL NAME OF (If not in hospital or institution, give street address or location)

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1740 E. Eager St.

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Female

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

April 16, 1897

9. AGE (In years  
last birthday)

53

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ga

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Mitchell Miles

14. MOTHER'S MAIDEN NAME

Sadie Clark

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHNS HOPKINS HOSPITAL

18. 443 X I

CAUSE OF DEATH

Lenticulo

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral Hemorrhage, right lenticulo-  
-stroke artery

4 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease

22-3 yrs

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-21, 1950, to 7-21, 1950, that I last saw the  
deceased alive on 7-21, 1950, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Thomas E. Van Metre Jr.

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

22 July 50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

July 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Rosedale cem

24D. LOCATION (City, town, or county)

Orange M. J.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams

25. FUNERAL DIRECTOR

George G. Kilson 1303 Presnam st

ADDRESS

JUL 24 1950

VS 150

72084 6433

93D

MEDICAL CERTIFICATION

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520

6435

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6435

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

George Young

2. DATE  
OF DEATH

July 21, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Cpl 67 -

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE

Md

B. COUNTY

Baltimore before admission)

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore - Essex

D. STREET ADDRESS (If rural, give location)

253 Stillwater Ave

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

3/27/1927

9. AGE (In years  
last birthday)

22

If Under 1 Year

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR  
INDUSTRY

Odd Jobs

11. BIRTHPLACE (State or foreign country)

Balto City Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frederick R Young, Jr.

14. MOTHER'S MAIDEN NAME

Anna. S. Mowdsels

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

217-22-9382

17. INFORMATION HOPKINS HOSPITAL

ADDRESS

18. 456X I

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Disseminated Lupus  
Erythematosus

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

8 mos.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-20-1950 to 7-21-1950, that I last saw the  
deceased alive on 7-21-1950, and that death occurred at 6:35 A.M. from the causes and on the date stated above.

23A. SIGNATURE

David Reuben

M. D.

23B. ADDRESS

JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

7-21-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

July 25, 1950

24C. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

24D. LOCATION (City, town, or county)

Balto Co Md

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

J. J. Brydgen, 1407 Eastern Ave.

ADDRESS

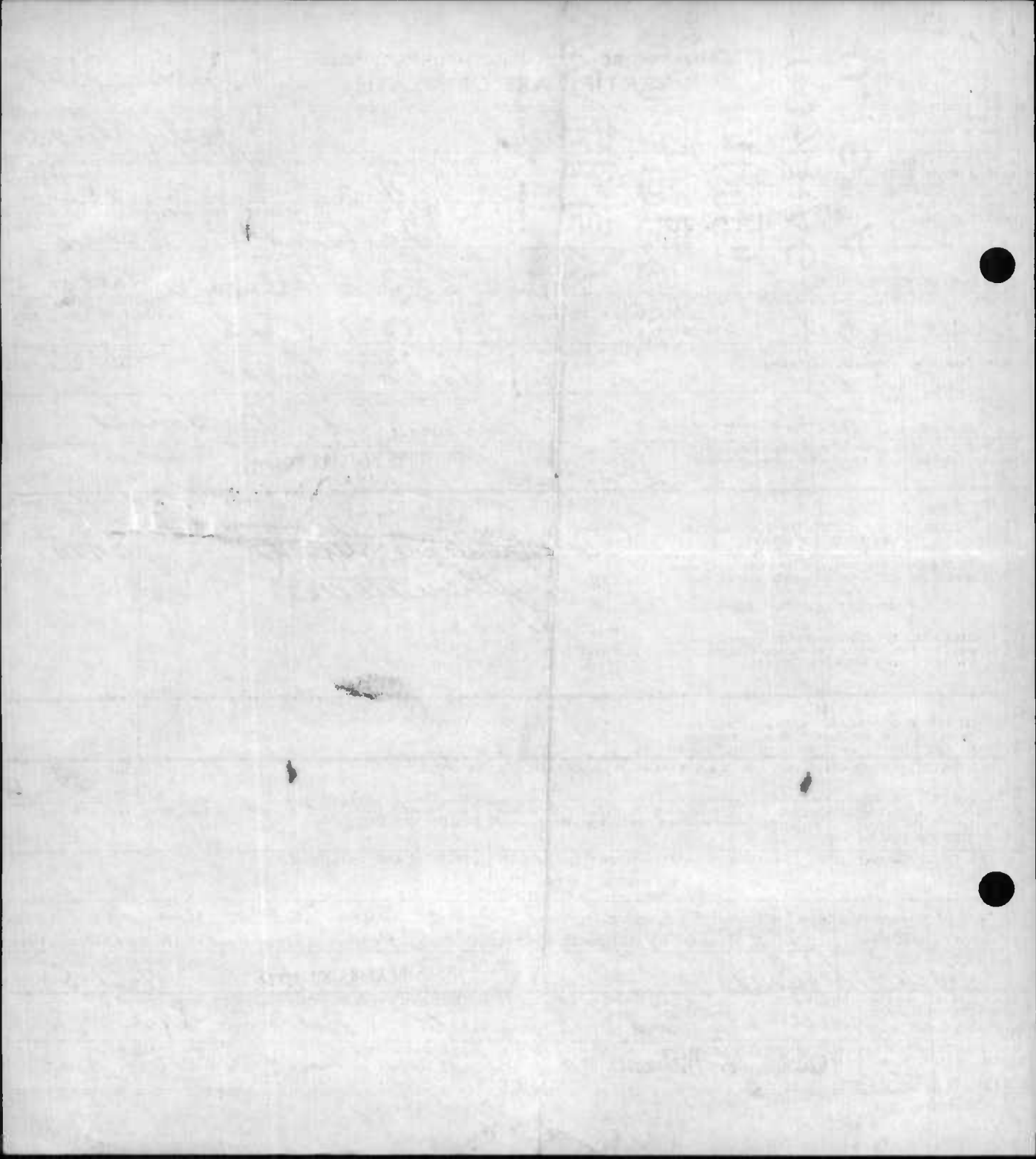
JUL 24 1950

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97099 6435

153

MEDICAL CERTIFICATION



160

## CERTIFICATE CORRECTED

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

50 6436

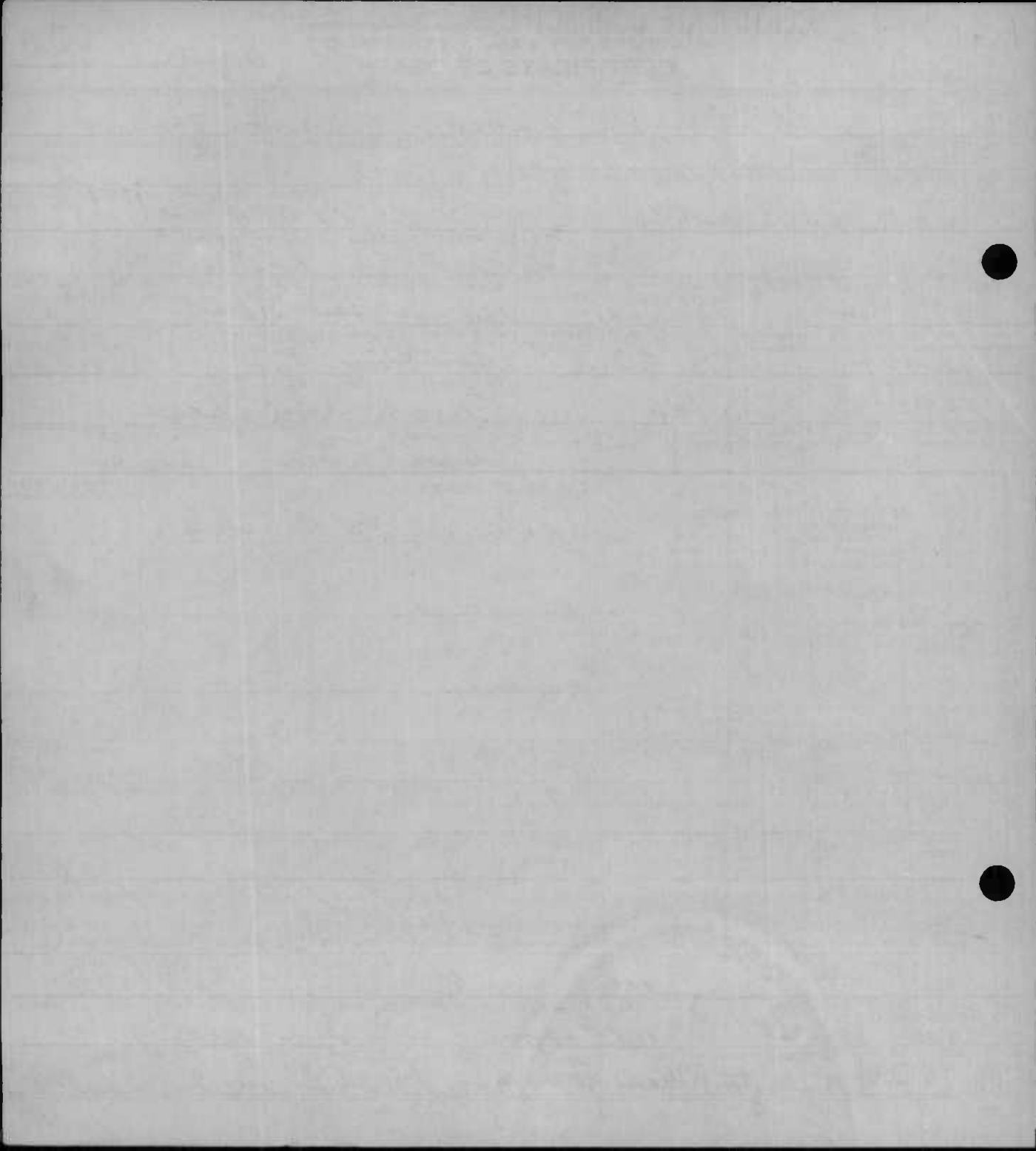
BIRTH NO. 6436

1. NAME OF DECEASED (Type or Print) <i>Wm S. Taber</i>		2. DATE OF DEATH <i>7/23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>27-48</i>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>5655 Lothian Rd</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
D. STREET ADDRESS (If rural, give location) <i>5655 Lothian Rd</i>		E. LENGTH OF STAY IN BALTIMORE Yrs. <i>30</i> Mos. <i>0</i> Days <i>0</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 22 1872</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>R.R. Clerk</i>	9. AGE (In years last birthday) <i>26 77</i>
13. FATHER'S NAME <i>Wm S. Taber</i>		11. BIRTHPLACE (State or foreign country) <i>Newport</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME <i>Sarah Goodspeed</i>
17. INFORMANT <i>Edward W Taber</i>		ADDRESS <i>Same</i>	

18. <i>4221</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic C. V. disease</i>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST. <i>II</i>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				

23A. SIGNATURE <i>[Signature]</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> M.D. MEDICAL INVESTIGATOR..... <input checked="" type="checkbox"/>		23C. DATE SIGNED <i>7/23/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>July 25/50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Mt Carmel</i>	24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 24 1950</i>		REGISTRAR'S SIGNATURE <i>Wmington Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>Henry H. Jenkins</i>
				ADDRESS <i>4905 York Rd.</i>





425  
50 6437CERTIFICATE CORRECTED 7-27-50  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6437  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>Race Wilson</i>		2. DATE OF DEATH <i>7/23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 9-03</i>	
D. STREET ADDRESS (If rural, give location) <i>620 Melville Ave</i>		E. LENGTH OF STAY IN BALTIMORE <i>LIFE</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>JAN 1, 1878</i>
9. AGE (In years last birthday) <i>68-72</i>		10. UNDER 1 YEAR: Months: Days	
11. UNDER 24 HOURS: Hours: Min.		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	
13. FATHER'S NAME <i>WM H. VERKES</i>		14. MOTHER'S MAIDEN NAME <i>ANN BOTH</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>RALPH WILSON</i>		ADDRESS <i>609 MELVILLE AVE</i>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Anteroseptatic C. U. disease</i>	CAUSE OF DEATH (A) <i>Anteroseptatic C. U. disease</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <i>Obesity</i>	(B) <i>Obesity</i> DUE TO	
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from Autopsy, Inspection or Inquiry the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
23A. SIGNATURE <i>R. P. Tubanski</i>	23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>	23C. DATE SIGNED <i>7/23/50</i>

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	24B. DATE <i>7-26-1950</i>	24C. NAME OF CEMETERY OR CREMATORY <i>BALTIMORE</i>	24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 24 1950</i>	REGISTRAR'S SIGNATURE <i>Thurston Williams</i>	25. FUNERAL DIRECTOR <i>H.W. JENKINS &amp; SONS</i>	
ADDRESS <i>4905 YORK RD</i>			

STATE OF NEW YORK

IN SENATE

JANUARY 1891

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

ON APRIL 18, 1890

ALBANY: J.B. LEECH, STATE PRINTER, 1891.

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50 6438

50 6438

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		GENEVIEVE MYERS NEW		July 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.			
B. FULL NAME OF HOSPITAL OR INSTITUTION 625 St. John Rd.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) Greenway Apts. - Charles & 34th Sts.			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 23, 1883	9. AGE (In years last birthday) 67	If Under 1 Year Months Days If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Joseph Albert Myers			
14. MOTHER'S MAIDEN NAME Grace Mackay		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Genevieve Emerson 625 St. John Rd.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 443X I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH Cerebrovascular Thrombosis Arteriosclerosis Myocarditis Hypertension (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs Gradual	
19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Aug 26 to July 23, 1950, that I last saw the deceased alive on July 23, 1950, and that death occurred at 6:30 am, from the causes and on the date stated above.					
23A. SIGNATURE J. H. Brady		23B. ADDRESS M. O. 1403 Park Ave		23C. DATE SIGNED July 24, 50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/25/50		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto., Md.		24E. FUNERAL DIRECTOR J. M. J. Fisher & Sons		24F. ADDRESS Balto Md.	
DATE RECEIVED BY LOCAL REGISTRAR JUL 24 1950		REGISTRAR'S SIGNATURE Huntington Williams, M.D.		24G. ADDRESS Balto Md.	

VALLEY  
CONCRETE  
CORP.

152

0 6439

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6439

Registered No.

1. NAME OF DECEASED (Type or Print) <b>BESSIE COVINGTON</b>			2. DATE OF DEATH <b>JULY 24, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>KENTUCKY</b> B. COUNTY <b>V-15</b>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>U.S. MARINE HOSPITAL</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>PADUCHA</b>		
c. Length of stay in Baltimore Yrs. <b>3</b> Mos. <b>4</b> Days			D. STREET ADDRESS (If rural, give location) <b>EMPIRE APTS. BOX 507</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>JUNE 6, 1900</b>	9. AGE (In years last birthday) <b>50</b>	10. Under 1 Year Months: <b>1</b> Days: <b>18</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEWARDESS</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SHIP</b>		
11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>ZEB JONES</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA ELIZABETH ROGERS</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>404-16-6407</b>		
17. INFORMANT <b>Mr. James I. Covington</b>			ADDRESS <b>Paducha, Ky.</b>		

18. <b>171X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Right pyonephrosis</b> DUE TO <b>Carcinoma of cervix uteri</b> DUE TO <b>10 MOS.</b>	CAUSE OF DEATH <b>4 MOS. (APPROX)</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>NONE</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **APRIL 20, 1950**, to **JULY 24, 1950**, that I last saw the deceased alive on **JULY 24, 1950**, and that death occurred at **3:40 a.m.**, from the causes and on the date stated above.

23A. SIGNATURE <b>Richard G. Saavedra</b>	23B. ADDRESS <b>U.S. MARINE HOSPITAL</b>	23C. DATE SIGNED <b>JULY 24, 1950</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>7/24/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Paducha, Ky.</b>	24D. LOCATION (City, town, or county) (State)
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. J. Tickers</b>	ADDRESS <b>482 Md</b>
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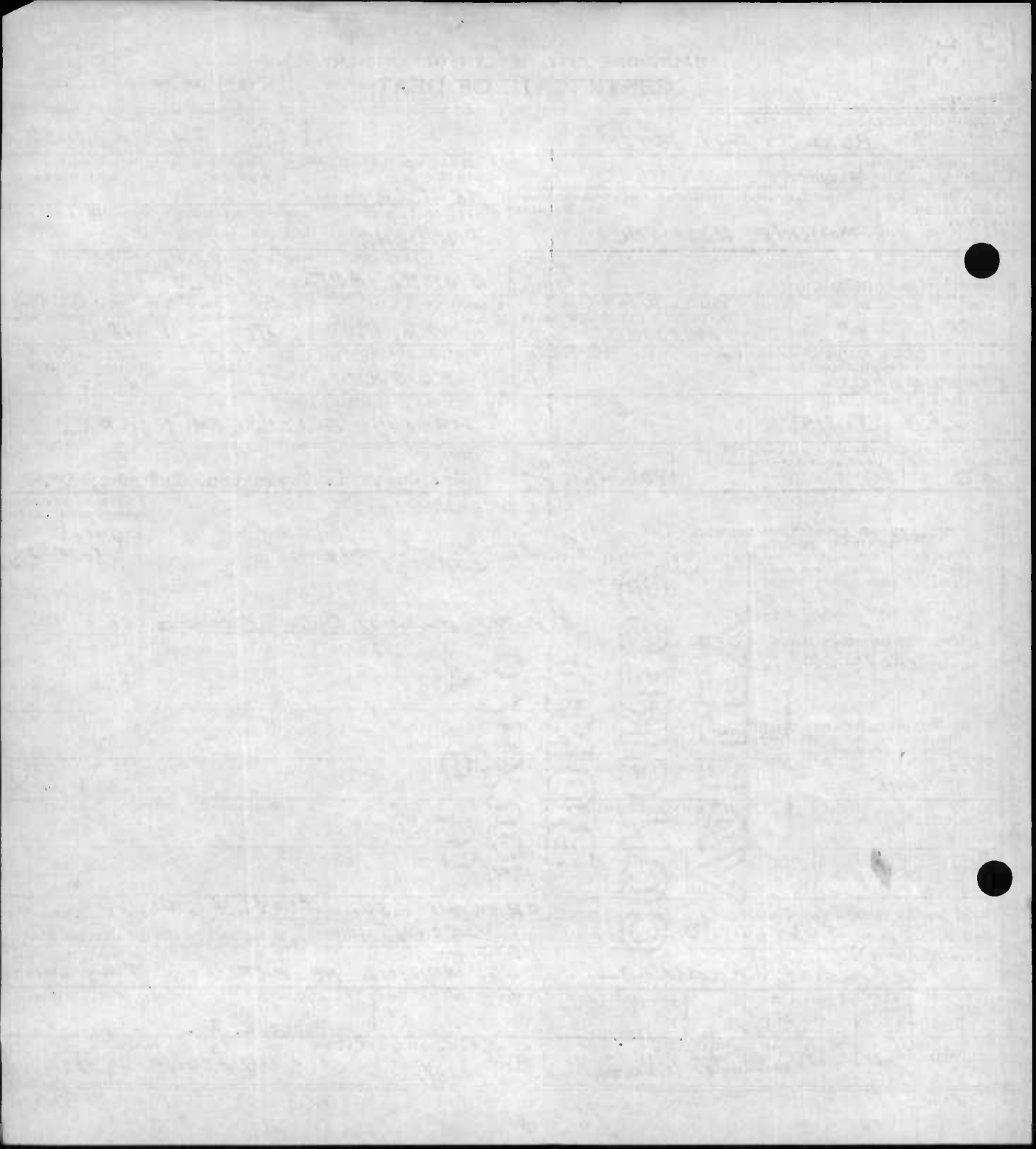
VS 150

76455-6439

482 Md

482 Md

MEDICAL CERTIFICATION





523  
50 6440BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6440

Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HERBERT ALBERT KNIGHT</b>		2. DATE OF DEATH <b>22 July 50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md</b> B. COUNTY <b>Balto</b>			
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of Maryland</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Arbutus 5900</b>			
C. Length of stay in Baltimore <b>less in Balto. County</b>		D. STREET ADDRESS (If rural, give location) <b>1243 Stevens Ave</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan 1; 1881</b>	9. AGE (In years last birthday) <b>69</b>	H Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>construction</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>gas &amp; electric</b>		11. BIRTHPLACE (State or foreign country) <b>Balto, md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>John M Knight</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Serbel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Edna Knight (wife) - 1243 Stevens</b>	
18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b> CAUSE OF DEATH <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>					
19A. DATE OF OPERATION <b>none</b>		19B. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) <b>none</b>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>none</b>	
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>none</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>none</b>	
22. I hereby certify that I attended the deceased from <b>January, 1947</b> to <b>22 July, 1950</b> , that I last saw the deceased alive on <b>22 July, 1950</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>William Goodman</b>		23B. ADDRESS <b>1334 Sutherland Spring Rd</b>		23C. DATE SIGNED <b>22 July 50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/25/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>					
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Tucker &amp; Sons, Balto, Md.</b>	

STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
JAN 11 1900

650  
50 6441

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6441

Registered No.

1. NAME OF DECEASED (Type or Print) <b>TERENCE HENRY FRANEY, Sr.</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-18</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>4926 Denmore Ave.</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 27, 1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Yellow Cab Co.</b>	9. AGE (In years last birthday) <b>50</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John J. Franey</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Boylan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>213-05-7787</b>	
17. INFORMANT <b>Terence H. Franey, Jr.</b>		ADDRESS <b>4926 Denmore Ave.</b>	

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) <b>Adams Stroke syncope of organic origin.</b> DUE TO (B) <b>Coronary atherosclerotic heart disease.</b> DUE TO (C) <b>Left iliac embolism.</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION <b>7/26/50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 10, 1950</b> to <b>July 23, 1950</b> , that I last saw the deceased alive on <b>July 23, 1950</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>B. B. Velez</b>		M. D. <b>1100 N. Caroline St.</b>		23B. ADDRESS <b>July 23, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/26/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) <b>Balto., Md.</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		24F. REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>	
24G. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		24H. REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		24I. FUNERAL DIRECTOR <b>Wm. J. Pickner &amp; Sons, Balto., Md.</b>	

VS 150  
68254  
94a

CERTIFICATE OF DEATH

DATE OF DEATH

1900



STATE OF TEXAS  
COUNTY OF DALLAS

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at Dallas, Texas, this 1st day of January, 1901.

1901



324

6443

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6443

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

LOUISE IDA MITCHELL

2. DATE  
OF  
DEATH

July 22, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)

HOSPITAL OR  
INSTITUTION 19 S. Payson St.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE  
Md.

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

19 S. Payson St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

May 4, 1878

9. AGE (In years last birthday)

72

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

-

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Wm. Finley Fisher

14. MOTHER'S MAIDEN NAME

Emma Betz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Myrtle Fisher - 2705 Garrison Blvd.

18. 420.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary occlusion

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

Hypertension and arteriosclerotic cardio-vascular disease

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 July, 1950, to 22 July, 1950, that I last saw the deceased alive on 22 July, 1950, and that death occurred at 1:10 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Emil W. Henning Jr. M.D.

601 Winans Way

23 July 50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

7/25/50

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1950

Huntington Williams, Jr.

Wm. J. Pickens &amp; Sons Balto.

STATE OF TEXAS

1901

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1914

1915

420  
50 6444

WALTON Lee BLAKE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 50 6444

1. NAME OF DECEASED (Type or Print) <i>Walton Lee Blake</i>			2. DATE OF DEATH <i>7/22/50</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>15-01</i>		
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>1600 Delano Ct</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>White Md 15-01</i>		
C. Length of stay in Baltimore <i>24 Yrs.</i>			D. STREET ADDRESS (If rural, give location) <i>1600 Delano Ct</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>7/31/07</i>		9. AGE (In years last birthday) <i>43</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>WAAM-Radio Station</i>		11. BIRTHPLACE (State or foreign country) <i>Phila., Pa.</i>
13. FATHER'S NAME <i>Erie Blake</i>			14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>155-05-4796</i>		
			17. INFORMANT <i>Mrs. Loney Mac Blake</i>		
			ADDRESS <i>1600 Delano Ct</i>		

18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Hypertensive Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (A) <i>Hypertensive Cardiovascular Disease</i>		
ANTECEDENT CAUSES		
DUE TO (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>7/24/50</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <i>Inspection</i> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>W. L. Williams, M.D.</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/> MEDICAL INVESTIGATOR..... <input checked="" type="checkbox"/>		23C. DATE SIGNED <i>7/23/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>7/24/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Woodlawn, N. J.</i>		25. FUNERAL DIRECTOR <i>Charles R. Law - 802 Madison Ave.</i>			
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 24 1950</i>		REGISTRAR'S SIGNATURE <i>W. L. Williams, M.D.</i>		ADDRESS <i>6828J</i>	

RECEIVED BY THE  
LIBRARY OF THE  
UNITED STATES OF AMERICA



363

Woodward

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6445

Registered No.

6445

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JENNIE WOODWARD

2. DATE  
OF  
DEATH

July 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

ST. JOSEPH'S HOSPITAL

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1651 E. EAGER ST.

C. Length of stay in Baltimore

34RS

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

WIDOW

8. DATE OF BIRTH

12/23/83

9. AGE (In years  
last birthday)

66

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

Selma Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

NOVELL HICKS 1651 Eager ST

18.

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A)

UREMIA

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

CHRONIC NEPHRITIS

DUE TO

(C)

ARTEROSCLEROSIS

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐NOT WHILE ☐

WORK

AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-27-1950 to 7-23-1950 that I last saw the  
deceased alive on 7-23-1950 and that death occurred at 12:50 A.M., from the causes and on the date stated above.

23A. SIGNATURE

B. B. B. B. B.

M. D.

23B. ADDRESS

1400 N. Caroline St.

23C. DATE SIGNED

7/23/50.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1950

VS 150

Mrs. Robert G. Elliott, Jr.

129 N. Caroline St 131a

MEDICAL CERTIFICATION

STATE OF MARYLAND

NOTARY PUBLIC FOR MARYLAND

NOTARY PUBLIC

My Commission Expires

My Commission Expires

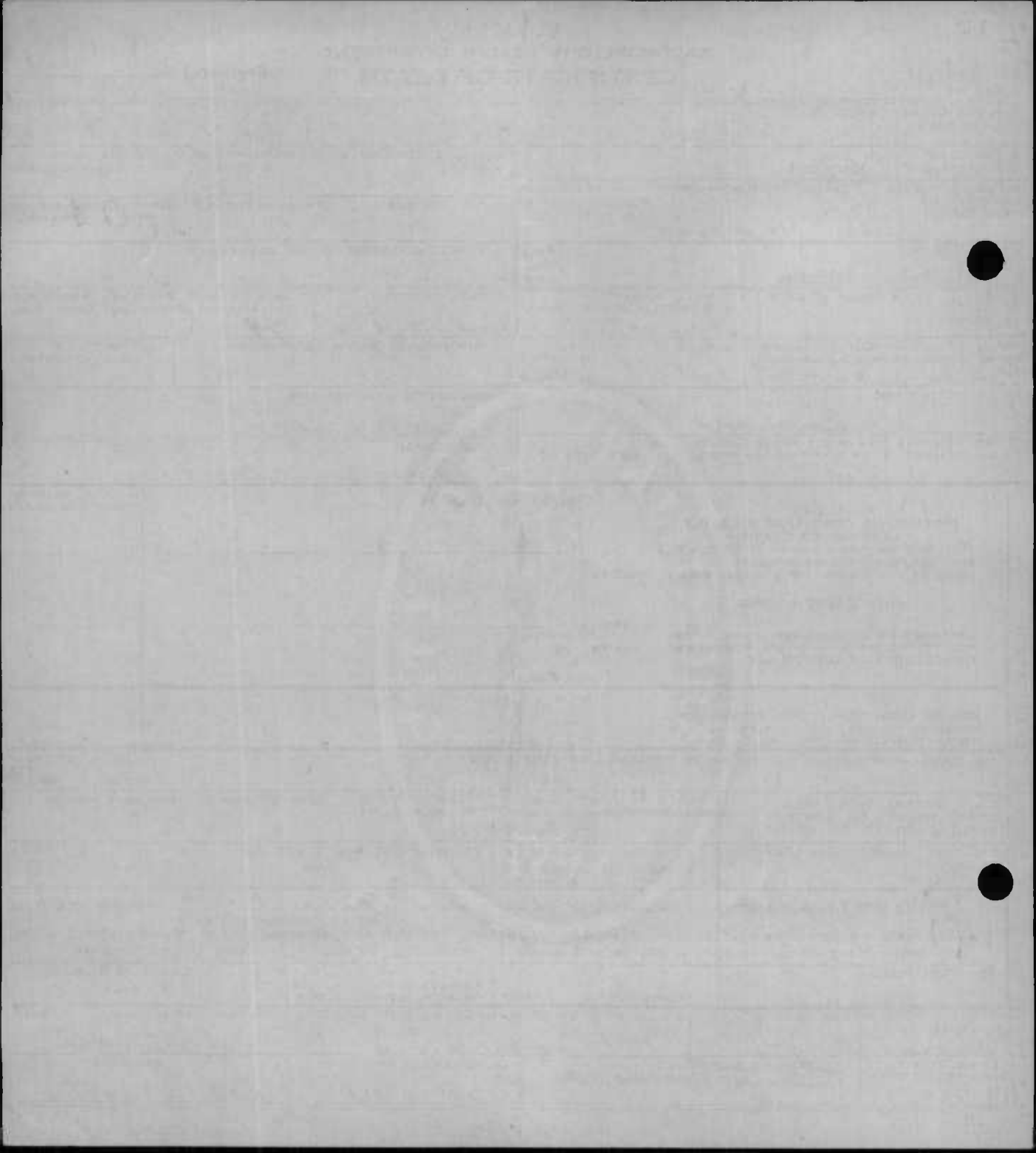
My Commission Expires

My Commission Expires

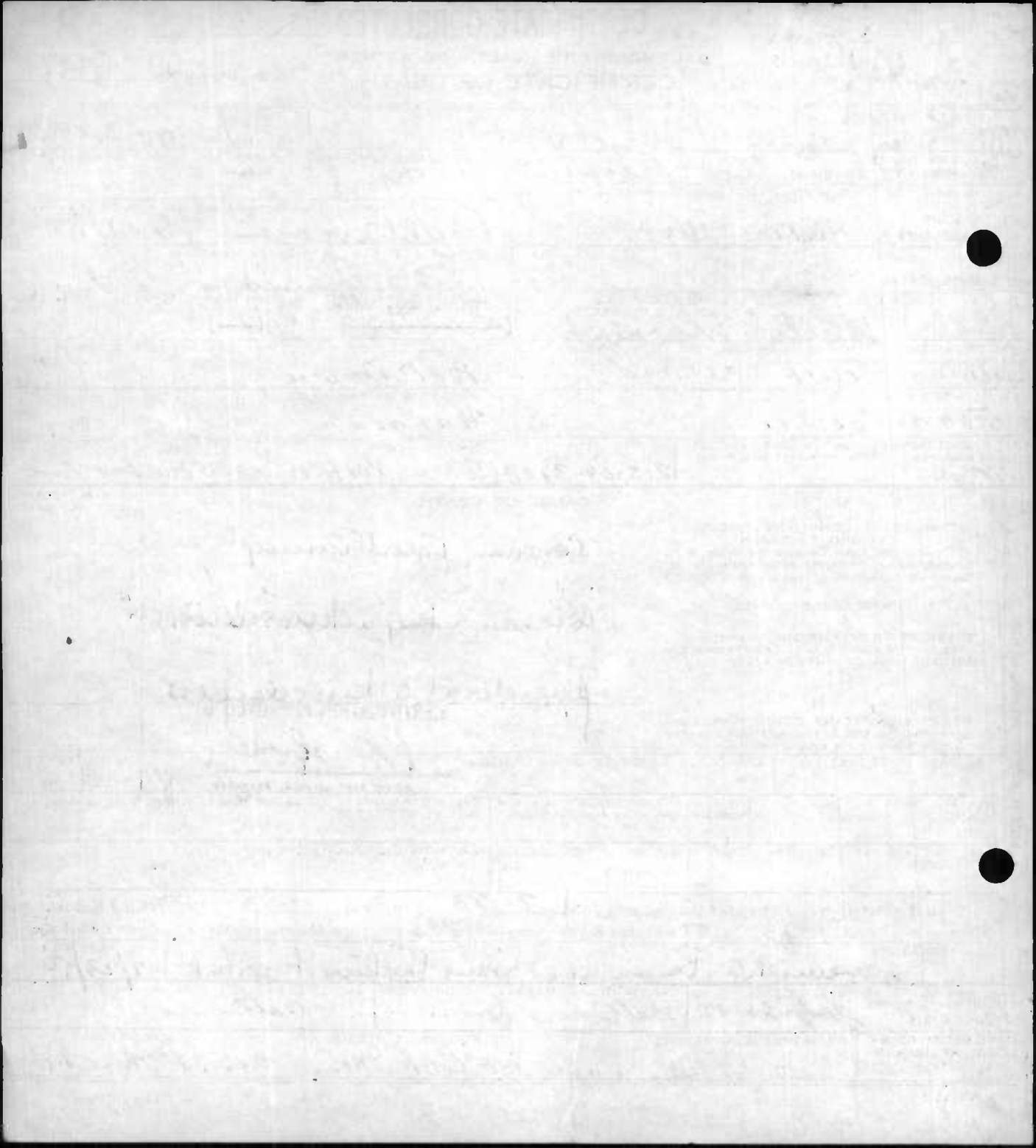


<div style="display: flex; justify-content: space-between;"> <span>200</span> <span>Weeks</span> </div> <div style="display: flex; justify-content: space-between;"> <span>6446</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>50 6446</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>		Registered No. <span style="font-size: 1.2em;">50 6446</span>	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Robert Weeks		7/23/50	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) John King		C. CITY OR TOWN (If outside corporate limits, write full name and give township) Cato Md 3-01	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1519 E Lombard St	
5. SEX	6. COLOR OF SKIN	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
M	C	Operated	July 15, 1876
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)
Retired Laborer Canton, Maryland			74
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unknown		W. Va.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no			Minnie Anderson
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Antagonistic C. U. disease DUE TO ANTECEDENT CAUSES (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an <u>Inspection</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
23A. SIGNATURE		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	
J. C. Tubenke		M.D. 7/23/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	July 26, 1950	Mt Calvary Cem	A. A. County Md
DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS	
JUL 24 1950	Huntington Williams, M.D.	Mrs Robert A. Elliott, Daughters	
VS 151 9706P 9311P 977. Caroline St ✓			

MEDICAL CERTIFICATION



b Med. Exams Case		CERTIFICATE CORRECTED		7-27-50	
Released to Hosp.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 50 6447	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		John Voelker		2. DATE OF DEATH July 23, 1950	
3. PLACE OF DEATH A. Baltimore City, Maryland		Acc. Room		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md	
B. FULL NAME OF HOSPITAL OR INSTITUTION		Johns Hopkins Hosp.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01	
c. Length of stay in Baltimore		Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) 1033 Harford Ave	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1880 (44-1879)	
Clothing Presser		Retired		9. AGE (In years last birthday) 69(7-0)	
13. FATHER'S NAME		John Voelker		11. BIRTHPLACE (State or foreign country) Baltimore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY?	
None		212-09-3808		14. MOTHER'S MAIDEN NAME Unknown	
17. INFORMANT		Warren Voelker		ADDRESS 1033 Harford Ave	
18. 420.1 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) Coronary Insufficiency			
DUE TO		(B) Coronary artery atherosclerosis			
ANTECEDENT CAUSES		(C) Generalized atherosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, (A) STATING THE UNDERLYING CONDITION LAST.		CERTIFICATION APPROVED BY			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		R. Fisher			
19A. DATE OF OPERATION 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7-23-1950 to 7-23-1950, that I last saw the deceased alive on 7-23-1950 and that death occurred at 4:30 m. from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
Geremiah A. Brandon		Johns Hopkins Hospital		7/23/50	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 26-50		Baltimore Cem.	
24D. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR		ADDRESS	
Baltimore		Wm. Cook & Co.		1210 St Paul St	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		VS 150	
JUL 24 1950		Huntington Williams, Jr.		To be approved by med. exam 69046	
				94a	



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6448

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Malcolm J. Stewart</b>		2. DATE OF DEATH <b>July 22 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Md.</b>		4. USUAL RESIDENCE (Where deceased lived, institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>John's Hopkins D.O.A.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Dundalk 5300</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1806 Matwell Ave</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>May-12-1905</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>45</b>
13. FATHER'S NAME <b>Charles M Stewart</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D.C</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>None</b>		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Sadie Proctor</b>	
17. INFORMANT <b>Mrs August Stewart: 1908 August Dr. Charles Silver Spring</b>			

18. <b>E974X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Hanging</b>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES <b>(B)</b>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(C)</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Police Station</b>	21C. WHERE DID INJURY OCCUR? <b>Bank St. near Broadway Eastern Police Station</b>
21D. TIME (Month) (Day) (Year) (Hour) INJURY <b>July 22, 1950 8:13 P.m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Hanged self with belt on cell door</b>

22. I certify that I took charge of the remains described above, held an **Inspection** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23A. SIGNATURE <b>William Updette</b>	23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED <b>July 13 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 24-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St Peter's</b>
24D. LOCATION (City, town, or county) <b>Baltimore</b>		

DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>	REGISTRAR'S SIGNATURE <b>Washington Williams, Jr</b>	25. FUNERAL DIRECTOR <b>Wm Cook Inc - 1217 St Paul St</b>	ADDRESS
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CONFIDENTIAL - SECURITY INFORMATION

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BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6449

-250  
50 6449  
BIRTH NO.1. NAME OF DECEASED  
(Type or Print)

Solomon Mason

2. DATE  
OF  
DEATH

7/23/50

3. PLACE OF DEATH:

a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

b. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTIONc. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

d. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (in years  
last birthday)If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10a. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10b. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James B. Mason

14. MOTHER'S MAIDEN NAME

Letitia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
211-9-8153

17. INFORMANT

ADDRESS

Mrs. Paul Biedler, 2802 N. Calvert St.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) ..... Autopsy ..... R. V. Biedler

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

DUE TO

(C) .....

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21a. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21b. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21c. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21d. TIME (Month) (Day) (Year) (Hour)  
INJURY

21e. INJURY OCCURRED

m. WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23a. SIGNATURE

J. M. Biedler

M.D.

23b. CHIEF MEDICAL EXAMINER.....☐ASSISTANT MEDICAL EXAMINER.....☐

23c. DATE SIGNED

MEDICAL INVESTIGATOR.....☐

7/23/50

24a. BURIAL, CREMA-  
TION, REMOVAL (Specify)  
removal

24b. DATE

7/24/50

24c. NAME OF CEMETERY OR CREMATORY

Maplewood

24d. LOCATION (City, town, or county)

Durham, North Carolina

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

J. M. Biedler

25. FUNERAL DIRECTOR

Wm. Cook, Inc.

ADDRESS

1217 St. Paul Street

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

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# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

50 6450

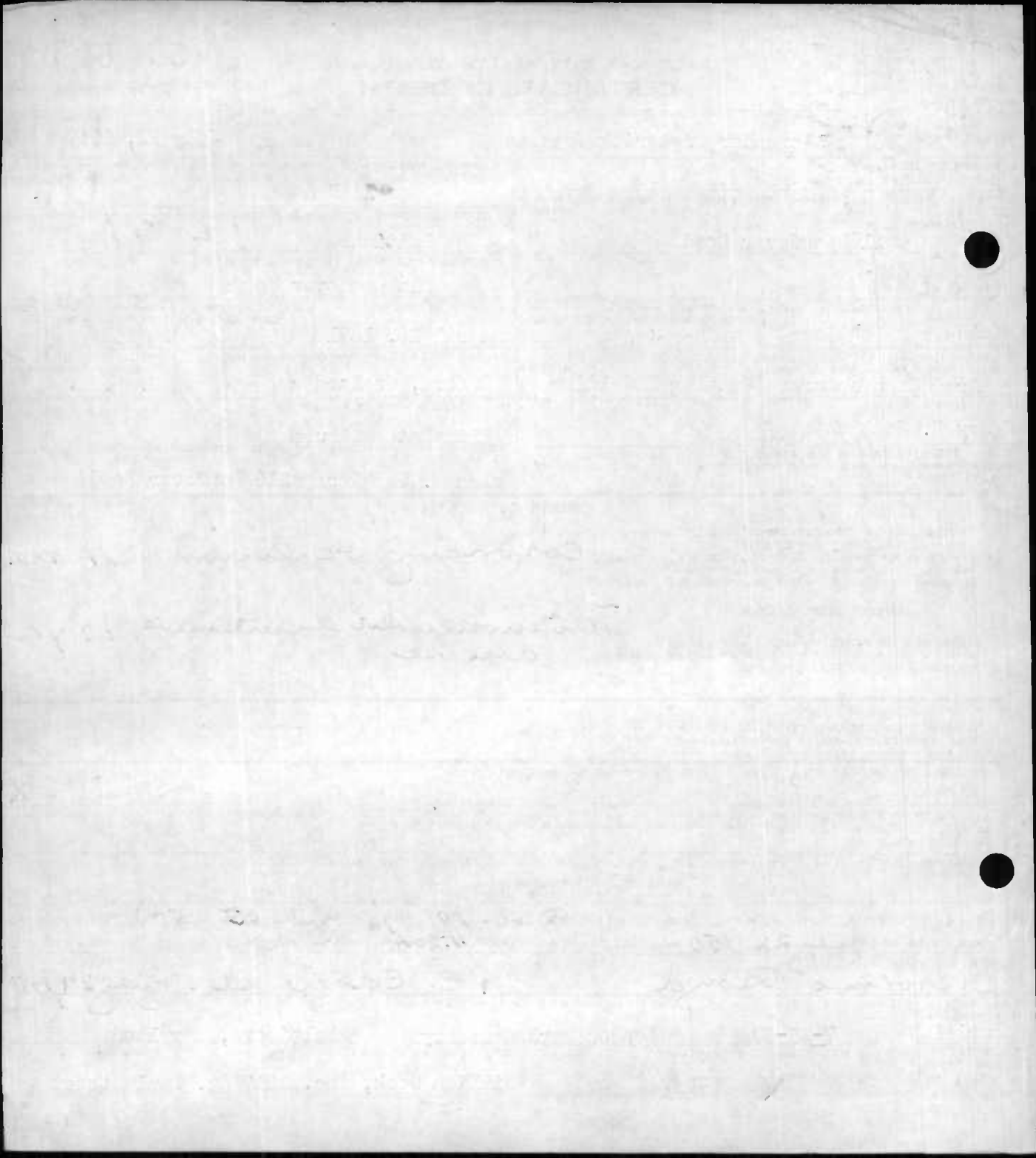
Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Alexander Frederick Jenkins</b>			2. DATE OF DEATH <b>July 22, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>216 Wendover Road</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____			D. STREET ADDRESS (If rural, give location) <b>216 Wendover Road</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 29, 1871</b>	9. AGE (In years last birthday) <b>79</b>	10. Under 1 Year Months: Days <b>2 23</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Manufacturer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Cutting &amp; Welding Equipment</b>		
11. BIRTHPLACE (State or foreign country) <b>Oxford, England</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Henry E. Jenkins</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Milburn</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknowns) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Helen W. Jenkins 216 Wendover Road</b>		

18. <b>447X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CORONARY OCCLUSION</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>11 hrs.</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic angstenia disease</b> DUE TO		<b>10 yrs.</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONOITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 10, 1948</b> to <b>July 22, 1950</b> that I last saw the deceased alive on <b>July 22, 1950</b> and that death occurred at <b>11:20 A.M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>C. Holmes Boyd</b>		23B. ADDRESS <b>24 E. Eager St.</b>		23C. DATE SIGNED <b>July 27 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-25-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>	REGISTRAR'S SIGNATURE <b>Huntington Williams, Jr.</b>	25. FUNERAL DIRECTOR ADDRESS <b>William Cook, Inc. 1217 St. Paul Street</b>			

94a



513  
50 6451BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6451  
Registered No.

BIRTH NO.			2. DATE OF DEATH 7-21-50		
1. NAME OF DECEASED (Type or Print) Mary E. Hampton			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
3. PLACE OF DEATH: A. Baltimore City, Maryland			A. STATE Maryland		
B. FULL NAME OF (If not in hospital or institution, give street address or location) Maryland Gen. Hospital			C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 12-07		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) 416 Tuxedo Street		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH May 16, 1963	9. AGE (in years last birthday) 87	10 Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY own home			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George H. McComas			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mr. Carlin M. Martin, 416 Tuxedo Street			ADDRESS		

18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) Myocardial Insufficiency DUE TO (B) Atherosclerotic Cardiovascular Disease DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown
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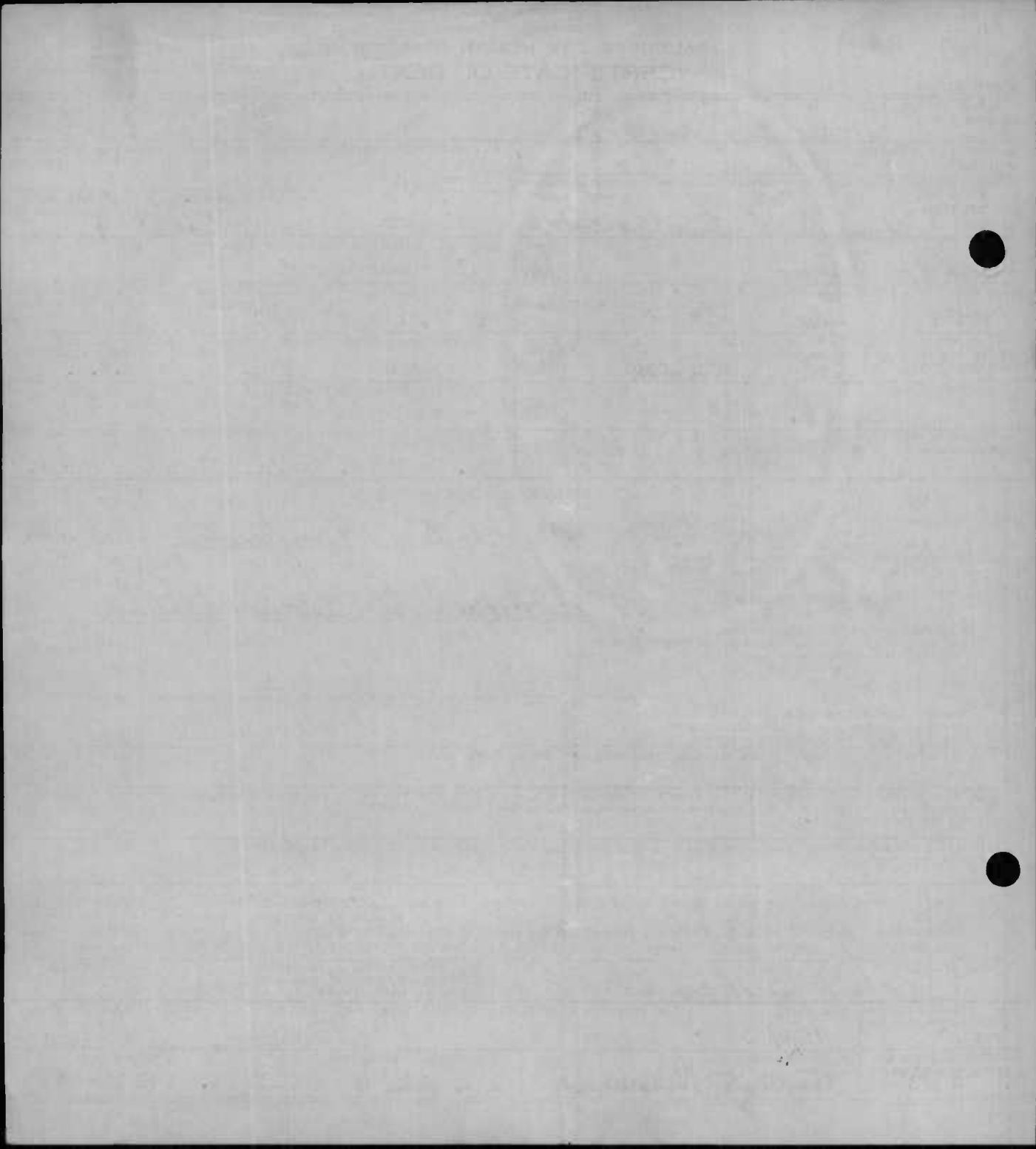
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Robert B. McAdams M.D.	23B. CHIEF MEDICAL EXAMINER..... ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....	23C. DATE SIGNED 7-24-50
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24A. BURIAL / CREMATION. REMOVAL (Specify) burial	24B. DATE 7/24/50	24C. NAME OF CEMETERY OR CREMATORY Western	24D. LOCATION (City, town, or county) Baltimore, Maryland
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DATE RECEIVED BY LOCAL REGISTRAR JUL 24 1956	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR 24 M. Cook, Inc.	ADDRESS 1217 St. Paul Street
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622  
0 6452BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6452

1. NAME OF DECEASED (Type or Print) <i>Joseph P. Markiewicz</i>			2. DATE OF DEATH <i>July 24-1950</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. City</i>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>35-49 Lyndale ave Md.</i> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <i>3549 Lyndale Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto 26-03</i>		
C. Length of stay in Baltimore <i>Life</i>			D. STREET ADDRESS (If rural, give location) <i>3549 Lyndale Ave.</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jun 17-1903</i>	9. AGE (In years last birthday) <i>47</i>	10. Under 1 Year Months Days 11 Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Roma Wines &amp; L. (W)</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			13. FATHER'S NAME <i>Michael Markiewicz</i>		
14. MOTHER'S MAIDEN NAME <i>Catherine Rulewicz</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>213-03-6099</i>			17. INFORMANT ADDRESS <i>Antoinette Markiewicz 3549 Lyndale Ave</i>		

MEDICAL CERTIFICATION	18. <i>196X</i>	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH
	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)	(A) <i>metastatic adenocarcinoma</i>	<i>2 months</i>
	ANTECEDENT CAUSES	(B) <i>adenocarcinoma left maxilla</i>	
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <i>5/24/50</i>	19B. MAJOR FINDINGS OF OPERATION <i>Adenocarcinoma left maxilla</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>1 June, 1950</i> , to <i>7/24</i> , 1950 that I last saw the deceased alive on <i>7/24</i> , 1950, and that death occurred at <i>6:50</i> p. m., from the causes and on the date stated above.		
23A. SIGNATURE <i>Stanley B. Klyanowicz M.D.</i>	23B. ADDRESS <i>3500 Erdman Ave</i>	23C. DATE SIGNED <i>7/24/50</i>
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>July 28-50</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Holy Rosary</i>
24D. LOCATION (City, town, or county) (State) <i>Balto. Co.</i>	25. FUNERAL DIRECTOR <i>Wm. S. Fialkowski</i>	ADDRESS <i>2007 Eastern Ave</i>
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 24 1950</i>	REGISTRAR'S SIGNATURE <i>Huntington Williams</i>	
<i>S. B. Klyanowicz 49068</i>		



40  
6453

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6453

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Vogel, Charles William

2. DATE  
OF

DEATH July 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or

HOSPITAL OR  
INSTITUTION

U. S. Marine Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

104 W. University Pkwy.

c. Length of stay in Baltimore

unkn

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Aug 8, 1870

9. AGE (in years last birthday)

79

If Under 1 Year Months: Days

If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician - Retired

10B. KIND OF BUSINESS OR INDUSTRY

U.S. Public Health Surgeon

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Philip Vogel

14. MOTHER'S MAIDEN NAME

Maria M. Mueller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

no

(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

no

17. INFORMANT

Records

ADDRESS

US Marine Hospital

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

15 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary sclerosis

unkn

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

no

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22, 1950 to July 23, 1950 that I last saw the deceased alive on July 23, 1950, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE

Richard A. Saavedra

23B. ADDRESS

U. S. Marine Hospital

23C. DATE SIGNED

7/23/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

July 26, 1950

24C. NAME OF CEMETERY OR CREMATORY

Landon Park

24D. LOCATION (City, town, or county)

City

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

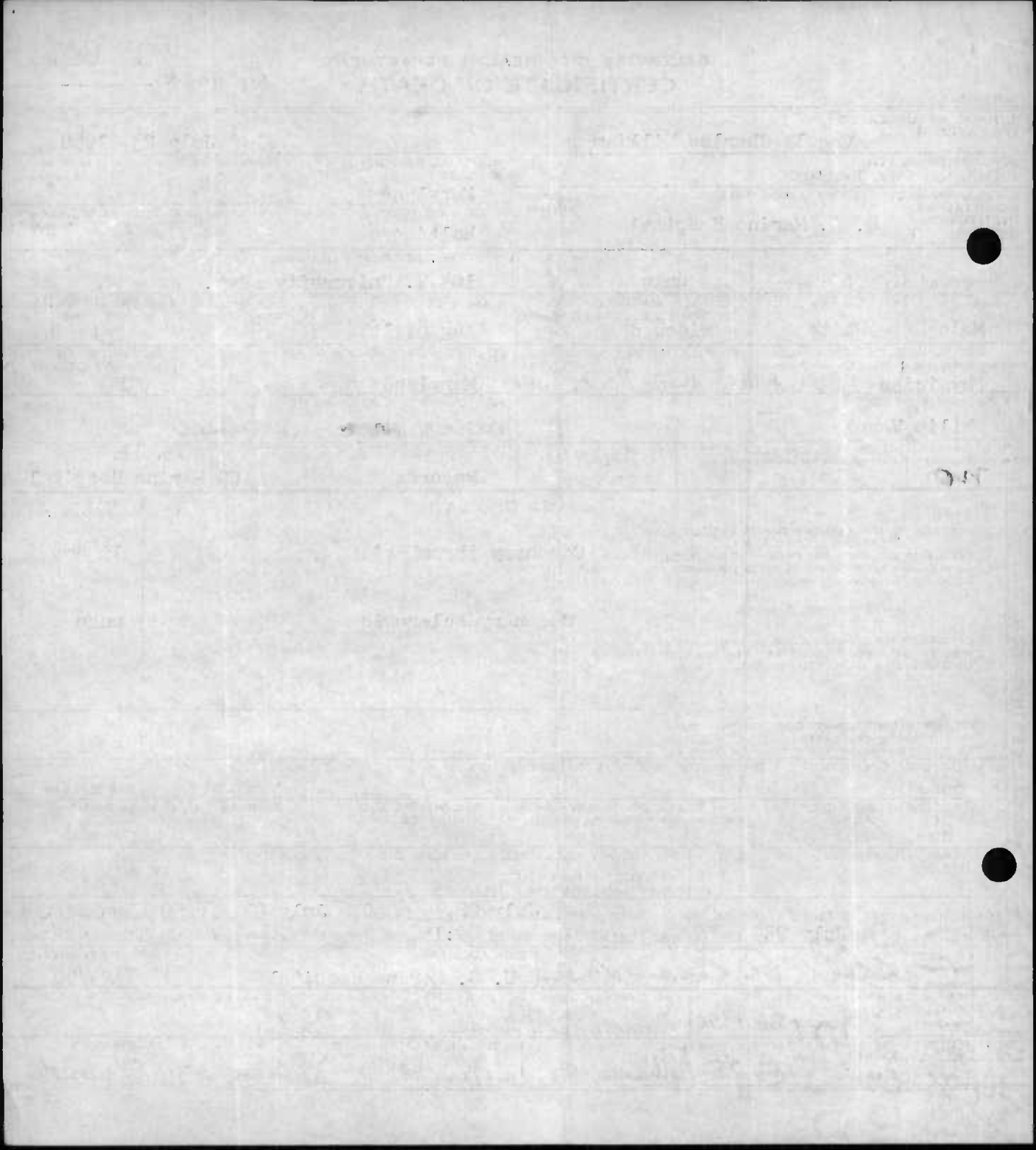
Mrs. Mrs. John W. Kufel & Son 5311 Edmondson

JUL 24 1950

VS 150

942 ave

MEDICAL CERTIFICATION



236  
50 6454

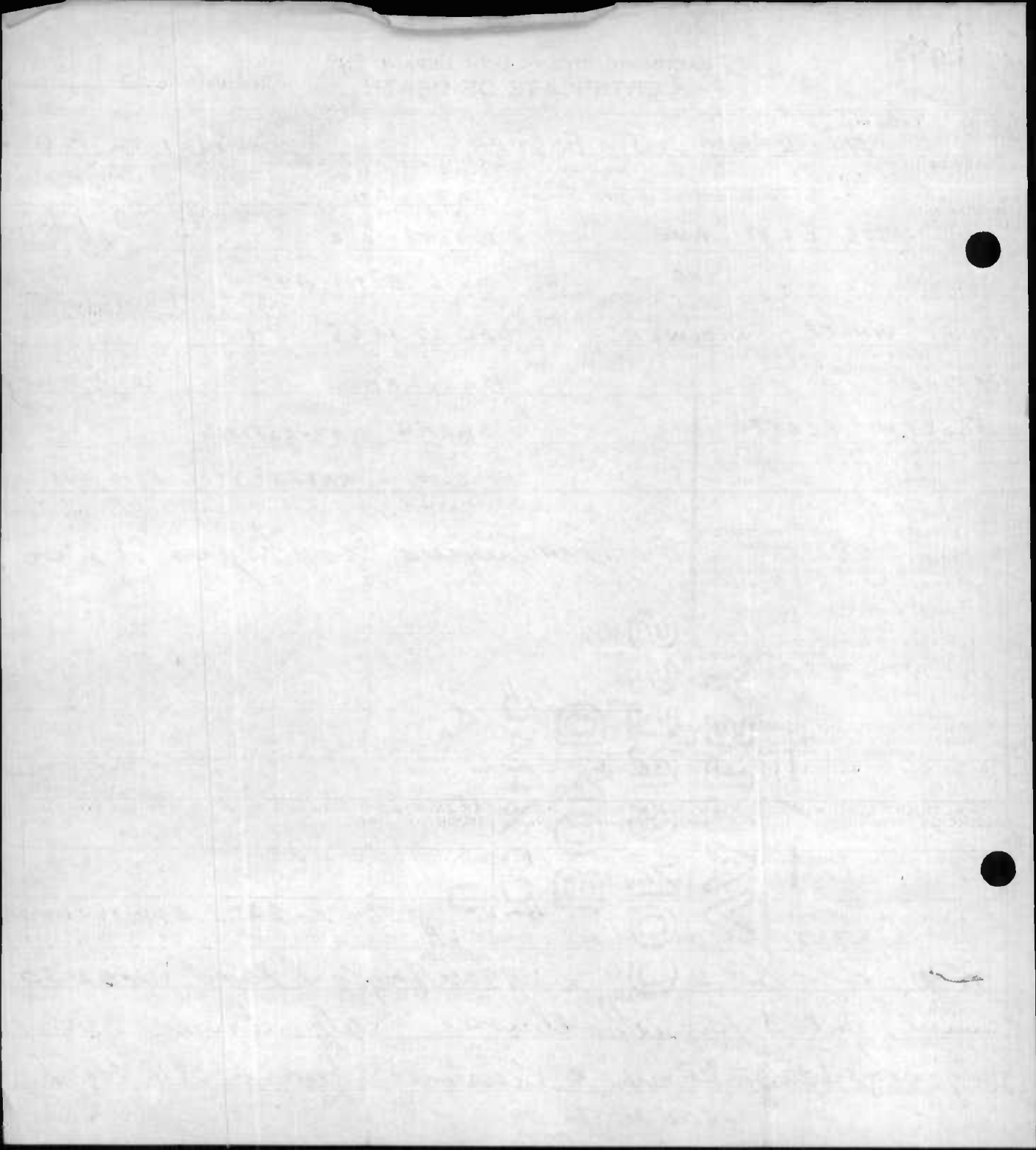
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6454  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM J. FOSTER</b>		2. DATE OF DEATH <b>JULY 22, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>13-07</b>	
b. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>3916 ELM AVE</b>		c. CITY OR TOWN <b>BALTIMORE</b>	
c. Length of stay in Baltimore <b>LIFE</b>		d. STREET ADDRESS (If rural, give location) <b>3916 ELM AVE</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWER</b>	8. DATE OF BIRTH <b>DEC 27, 1865</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>84</b> If Under 1 Year: Months: Days: Hours: Min.
13. FATHER'S NAME <b>JOSEPH FOSTER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>SARAH HARVESTING</b>	
17. INFORMANT <b>FLOSSIE L. WATTS-3916 ELM AVE.</b>		ADDRESS	

18. <b>150X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Esophagus</b> DUE TO <b>1 year</b>	CAUSE OF DEATH <b>Carcinoma Esophagus</b> DUE TO <b>1 year</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION <b>0</b>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21d. TIME (Month) (Day) (Year) (Hour) INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-4-</b> , 19 <b>50</b> to <b>7-22-</b> , 19 <b>50</b> that I last saw the deceased alive on <b>7-21-</b> , 19 <b>50</b> , and that death occurred at <b>1 P</b> m., from the causes and on the date stated above.					
23a. SIGNATURE <b>L. M. Peake</b>		23b. ADDRESS M. D. <b>4508 Hanford Road</b>		23c. DATE SIGNED <b>7-22-50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>July 24/50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	
24d. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>		24e. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		24f. LOCATION (City, town, or county) (State) <b>Woodlawn Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>William J. Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Justin E. Donovan</b>	
VS 150		ADDRESS <b>3818 Roland Ave</b>		46a	





562

0 6455

BIRTH NO. 50-14642

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6455

Registered No.

1. NAME OF DECEASED (Type or Print) <b>Baby Boy Somers</b>			2. DATE OF DEATH <b>7/21/50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland ✓			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Balt Maryland</b> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-28</b>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>1559 Northern Parkway</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Infant</b>	8. DATE OF BIRTH <b>7/21/50</b>		9. AGE (In years last birthday) <b>1</b> Under 1 Year Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John Somers</b>			14. MOTHER'S MAIDEN NAME <b>Evelyn Travolis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS		

18. <b>762.5</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Atalectasis</b> DUE TO <b>Prematurity</b>	CAUSE OF DEATH <b>Atalectasis</b> <b>Prematurity</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 15"</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7</b>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-21**, 19**50**, to **7-21**, 19**50** that I last saw the deceased alive on **7-21**, 19**50** and that death occurred at **6 a. m.**, from the causes and on the date stated above.

23A. SIGNATURE **John J. Fisher** M. D. 23B. ADDRESS **St Agnes Hospital** 23C. DATE SIGNED **7/23/50**

24A. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24B. DATE **7/25/50** 24C. NAME OF CEMETERY OR CREMATORY **GREEK Orthodox Cem** 24D. LOCATION (City, town, or county) (State) **BALTIMORE, County**

DATE RECEIVED BY LOCAL REGISTRAR **JUL 24 1950** REGISTRAR'S SIGNATURE **Huntington Williams, M.D.** 25. FUNERAL DIRECTOR **George S. Agnew Funeral Home** ADDRESS **118 W. Mt. Royal Ave. 159**

VS 150

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO  
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CERTIFICATE CORRECTED

7-21-50

050 6456

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6456

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

*Ankor Olat Burg AUKER BERG*

2. DATE  
OF  
DEATH

*July 22 1950*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *Baltimore Md.*

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

*Michigan*

B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION

*Lord Baltimore Hotel*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

*Monroe*

D. STREET ADDRESS (If rural, give location)

*706 Waterloo Drive*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

*M*

6. COLOR OR RACE

*W*

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
*married*

8. DATE OF BIRTH

*June 26, 1898*

9. AGE (In years last birthday)

*52*

If Under 1 Year  
Months: Days

If Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
*Sales Engineer*

10B. KIND OF BUSINESS OR INDUSTRY  
*Hoffman Engineering Co.*

11. BIRTHPLACE (State or foreign country)

*Norway*

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Frank Berg*

14. MOTHER'S MAIDEN NAME

*Anna Aumson*

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Rupp Funeral Home, Monroe, Michigan*

18. *420.1*

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) *Coronary Thrombosis*

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an \_\_\_\_\_ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

*William H. Smith*

23B. CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

M.D. MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED

*July 23 1950*

24A. BURIAL, CREMATION, REMOVAL (Specify)  
*removal*

24B. DATE

*7/24/50*

24C. NAME OF CEMETERY OR CREMATORY

*Roselawn*

24D. LOCATION (City, town, or county) (State)

*La Salle, Michigan*

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

*Christington Williams, M.D.*

25. FUNERAL DIRECTOR

ADDRESS

*Wm. Cook, Inc. 1217 St. Paul Street*

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6457  
Registered No. \_\_\_\_\_

245  
BIRTH NO. 6457

1. NAME OF DECEASED (Type or Print) <b>EMILY DOUGLASS GOSLINE</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>615 E. 34th St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore Yrs. _____ Mos. _____ Days _____		D. STREET ADDRESS (If rural, give location) <b>615 E. 34th St.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Mar. 16, 1869</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In year, last birthday) <b>81</b>
13. FATHER'S NAME <b>Harrison Douglass</b>		12. CITIZEN OF WHAT COUNTRY? <b>Mass.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>-</b>		16. SOCIAL SECURITY NO. _____	
14. MOTHER'S MAIDEN NAME <b>Mary J. Marvin</b>		17. INFORMANT ADDRESS <b>Miss Ethel L. Gosline 615 E. 34th St.</b>	

18. <b>420.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b> DUE TO	CAUSE OF DEATH	INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerotic heart disease + 20 yrs</b> DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes mellitus</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW OLD INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6 June, 1950</b> , to <b>23 July, 1950</b> , that I last saw the deceased alive on <b>17 July, 1950</b> , and that death occurred at <b>10<sup>15</sup> a.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Ind B. [Signature]</b>		23B. ADDRESS M. D. <b>2843 St Paul St</b>		23C. DATE SIGNED <b>24 July 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/25/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		
OATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, MD</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. J. Vickner &amp; Sons Balto Md.</b>	

MEDICAL CERTIFICATION

1941, 1942

1943, 1944

1945, 1946

1947, 1948

1949, 1950

1951, 1952

1953, 1954

1955, 1956

1957, 1958

1959, 1960

1961, 1962

1963, 1964

1965, 1966

1967, 1968

1969, 1970

1971, 1972

1973, 1974



50 6458  
Registered No. \_\_\_\_\_

BIRTH NO.

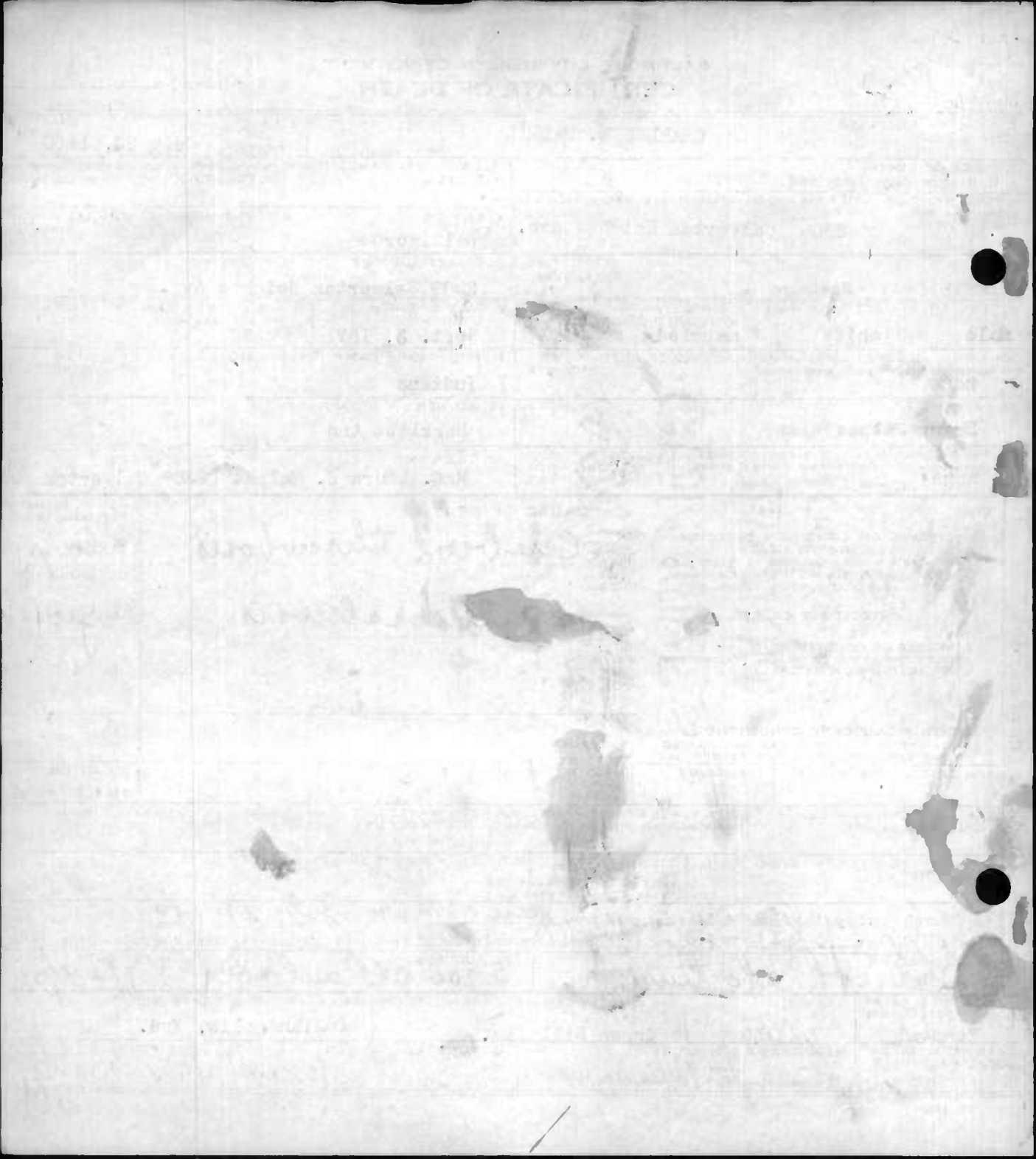
1. NAME OF DECEASED (Type or Print)		CHARLES E. MALPAS		2. DATE OF DEATH July 23, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 2309 Calverton Heights Ave.		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-05			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 2309 Calverton Heights Ave.			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Sept. 3, 1871	9. AGE (In years last birthday) 78	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Indiana	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Malpas		14. MOTHER'S MAIDEN NAME Harriett Ann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) none	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS Mrs. Laura B. Malpas 2309 Calverton Hs			

18. 332X	DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
	(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A)	Cerebral thrombosis	3 days	
	ANTECEDENT CAUSES		DUE TO	arteriosclerosis	2 years	
	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)				

MEDICAL	19A. DATE OF OPERATION 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
	21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
	22. I hereby certify that I attended the deceased from Jan 1940, to July 22, 1950, that I last saw the deceased alive on July 21, 1950, and that death occurred at 2:45 Am., from the causes and on the date stated above.					
	23A. SIGNATURE Cyberth. Mortimer Jr. M. D.		23B. ADDRESS 2706 SW Paulsk		23C. DATE SIGNED 7/24/50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Removal	24B. DATE 7/24/50	24C. NAME OF CEMETERY OR CREMATORY Crown Hill Cem.		24D. LOCATION (City, town, or county) (State) Indianapolis, Ind.		
DATE RECEIVED BY LOCAL REGISTRAR JUL 24 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.		25. FUNERAL DIRECTOR Thm. Lickner & Sons - Balt		ADDRESS Md	

VS 150

83 B



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6459

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6459  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Bessie Snowden Allen</u>		2. DATE OF DEATH <u>July 20/1950</u>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <u>Balto. City</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY			
B. FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> <u>7-05</u>			
C. Length of stay in Baltimore <u>Life</u>		D. STREET ADDRESS (If rural, give location) <u>1605 Mc Elderry St.</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>7-25-89</u>	9. AGE (In years last birthday) <u>60</u>	10. Under 1 Year Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ricerstown Md</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Andrews</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHNS HOPKINS HOSPITAL</u>	
18. <u>443X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Hypertensive and arteriosclerotic</u> DUE TO <u>cardiovascular disease with</u> (B) <u>congestive heart failure</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 1 yr</u>	
19A. DATE OF OPERATION <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7-18</u> , 19 <u>50</u> , to <u>7-20</u> , 1950 that I last saw the deceased alive on <u>7-20</u> , 19 <u>50</u> , and that death occurred at <u>10 P.m.</u> , from the causes and on the date stated above.					
23A. SIGNATURE <u>Thomas E. Van Metre Jr</u>		23B. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		23C. DATE SIGNED <u>7/21/50</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>7/24/1950</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Brooklyn A.A. Co Md</u>		25. FUNERAL DIRECTOR <u>Elroyo. Wilson</u>		ADDRESS <u>1000 B... ..</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 24 1950</u>		REGISTRAR'S SIGNATURE <u>Wmington Williams, M.D.</u>		935	

MEDICAL CERTIFICATION

NOTES ON THE HISTORY OF THE  
CITY OF NEW YORK

1790

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11/11/11

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11/11/11



62  
6461

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6461

BIRTH NO.	
1. NAME OF DECEASED (Type or Print) EDWARD JEFFRIES	
2. DATE OF DEATH July 21, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION 1217 St. Matthew Street	
6. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
7. STREET ADDRESS (If rural, give location) 1217 St. Matthew Street	
8. Length of stay in Baltimore 50 Yrs.	
9. SEX Male 10. COLOR OR RACE Colored 11. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	
12. DATE OF BIRTH Aug. 4, 1891 13. AGE (In years last birthday) 58	
14. BIRTHPLACE (State or foreign country) Richmond Va 15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Man 17. KIND OF BUSINESS OR INDUSTRY For Self	
18. FATHER'S NAME Unknown 19. MOTHER'S MAIDEN NAME Unknown	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No 21. SOCIAL SECURITY NO.	
22. INFORMANT ADDRESS Anna Jefferis 1217 St Mathewes St	

18. 327, 1, 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Chronic alcoholism (A) X	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty infiltration of the liver (B) X	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE William V. Brantley		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED July 22, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/26/1950		24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.	
24D. LOCATION (City, town, or county) (State) Brooklyn A.A. Co., Md		24E. FUNERAL DIRECTOR Thos. O. Wilson		24F. ADDRESS 1000 Brantley ave	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
DEATH CERTIFICATE

1-2-42

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth	
6. Date of death		7. Time of death		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of witness		14. Signature of funeral director		15. Signature of undertaker	
16. Signature of coroner		17. Signature of jury		18. Signature of jury		19. Signature of jury		20. Signature of jury	
21. Signature of jury		22. Signature of jury		23. Signature of jury		24. Signature of jury		25. Signature of jury	
26. Signature of jury		27. Signature of jury		28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury		34. Signature of jury		35. Signature of jury	
36. Signature of jury		37. Signature of jury		38. Signature of jury		39. Signature of jury		40. Signature of jury	
41. Signature of jury		42. Signature of jury		43. Signature of jury		44. Signature of jury		45. Signature of jury	
46. Signature of jury		47. Signature of jury		48. Signature of jury		49. Signature of jury		50. Signature of jury	
51. Signature of jury		52. Signature of jury		53. Signature of jury		54. Signature of jury		55. Signature of jury	
56. Signature of jury		57. Signature of jury		58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury		64. Signature of jury		65. Signature of jury	
66. Signature of jury		67. Signature of jury		68. Signature of jury		69. Signature of jury		70. Signature of jury	
71. Signature of jury		72. Signature of jury		73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury		79. Signature of jury		80. Signature of jury	
81. Signature of jury		82. Signature of jury		83. Signature of jury		84. Signature of jury		85. Signature of jury	
86. Signature of jury		87. Signature of jury		88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury		94. Signature of jury		95. Signature of jury	
96. Signature of jury		97. Signature of jury		98. Signature of jury		99. Signature of jury		100. Signature of jury	

250  
50 6462BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6462

1. NAME OF DECEASED (Type or Print) <b>Giovannina Buscemi</b>		2. DATE OF DEATH <b>July 21st 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>1617 Montpelier Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1617 Montpelier Ave</b>	
5. SEX <b>FE</b> <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>December 17 1875</b>
9. AGE (In years: last birthday) <b>74</b>		10. Under 1 Year: Months: Days <b>7</b>	
11. Under 24 Hours: Hours: Min. <b>4</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13. FATHER'S NAME <b>Vincenzo Arena</b>		14. MOTHER'S MAIDEN NAME <b>Francesca Padalina</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Francesca Orlando</b>		ADDRESS <b>1617 Montpelier Ave</b>	
18. <b>171X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of the cervix</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.		CAUSE OF DEATH <b>Carcinoma of the cervix</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>April 10, 1950</b> , to <b>July 21, 1950</b> , that I last saw the deceased alive on <b>July 29, 1950</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Irma Friedman</b>		23B. ADDRESS <b>1737 E. North Ave</b>	
23C. DATE SIGNED <b>7/22/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 25th 50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Baltimore Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	
25. FUNERAL DIRECTOR <b>Frank Delloso</b>		ADDRESS <b>322 S. High St.</b>	



620 50 6463

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6463

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elmer Ayers

2. DATE  
OF  
DEATH

7/22/50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence

A. STATE

B. COUNTY

before admission)

Md.

Baltimore City

B. FULL NAME OF (If not in hospital or institution, give street address or location)

Church Home &amp; Hospital

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

Baltimore 27-17

HOSPITAL OR INSTITUTION

D. STREET ADDRESS (If rural, give location)

3067 Spaulding Ave

C. Length of stay in Baltimore

1 yr

Yrs.  
Mos.  
Days

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

May 29, 1889

9. AGE (In years last birthday)

61

H Under 1 Year Months Days

H Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Engineer

10B. KIND OF BUSINESS OR INDUSTRY

B &amp; O R.R.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Robert Ayers

14. MOTHER'S MAIDEN NAME

Mary Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Hospital Records

18. 204.1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

Acute Myeloid Leukemia

INTERVAL BETWEEN ONSET AND DEATH

2 wks

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

Hemorrhagic Diathesis

1 wk

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-22-1950 to 7-22-1950, that I last saw the deceased alive on 7-22-1950, and that death occurred at 1033 m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 24 1950

Loring Byers, M.D.

Loring Byers, 5005 Philadelphia Ave.

VS 150

541500402

74a

MEDICAL CERTIFICATION

Graph 10-13

5 Transcribed

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50 6464

MERIT

X  
50 6464

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. \_\_\_\_\_

BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <i>Don L Merit</i>		2. DATE OF DEATH <i>July 24-1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2616 Maryland Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Illinois</i> B. COUNTY <i>V-11</i>			
5. FULL NAME OF HOSPITAL OR INSTITUTION _____		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Shamberg</i>			
c. Length of stay in Baltimore 10 Yrs. <i>10</i> Mon. <i>None</i> Days _____		D. STREET ADDRESS (If rural, give location) _____			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Aug 19-1891</i>	9. AGE (In years last birthday) <i>58</i>	H Under 1 Year Months: Days H Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Shoe (R)</i>		11. BIRTHPLACE (State or foreign country) <i>Shamberg Ills.</i>	
13. FATHER'S NAME <i>Charles Merit</i>		14. MOTHER'S MAIDEN NAME <i>Harriet C. Osley</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>357-09-3390</i>		17. INFORMANT ADDRESS <i>Mrs. Ella L. Merit 2616 Maryland Ave</i>	
18. <i>144X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Terminal Bronch. Pneumonia.</i>		(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO <i>Carcinoma 2 months c metastasis to lungs and liver</i>		(C) DUE TO		<i>12-15 mo</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 1947</i> , to <i>July 24</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 24</i> , 19 <i>50</i> , and that death occurred at <i>3:25 A.M.</i> , from the causes and on the date stated above.					
23A. SIGNATURE <i>E. L. Smith MD</i>		23B. ADDRESS <i>642 Wash. Blvd</i>		23C. DATE SIGNED <i>7-24-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24B. DATE <i>July 25-1950</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Resurrection Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Shamberg Livingston Ills</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 24 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Thurston Williams, MD</i>	
25. FUNERAL DIRECTOR <i>Thurston Williams, MD</i>		ADDRESS <i>490 6F</i>			

MEDICAL CERTIFICATION

45C

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Date of registration	

200  
50 6465BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6465

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Heyward E. Boyce. 434690

2. DATE  
OF  
DEATH

JUL 23 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL, and give township)

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)10 Under 1 Year  
Months Days Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)10B. KIND OF BUSINESS OR  
INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Hemorrhage from esophageal varices

10-15 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) cirrhosis of liver

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-12-1950 to 7-23-1950, that I last saw the  
deceased alive on 7-23-1950, and that death occurred at 6:45 A. M., from the causes and on the date stated above.

23A. SIGNATURE

James C. Dandell, Jr.

23B. ADDRESS

M. D.

23C. DATE SIGNED

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

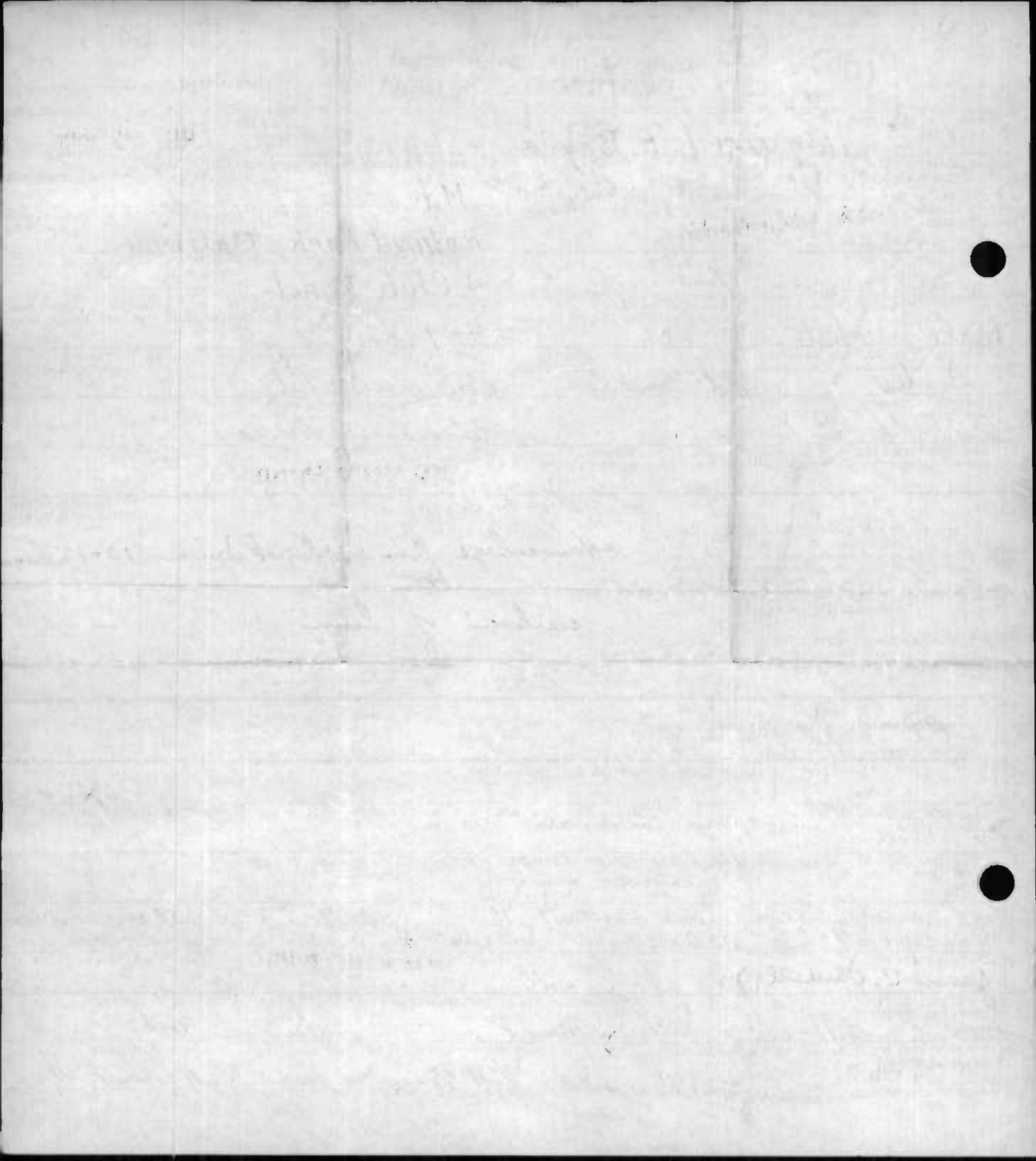
25. FUNERAL DIRECTOR

ADDRESS

VS 150

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50 6466

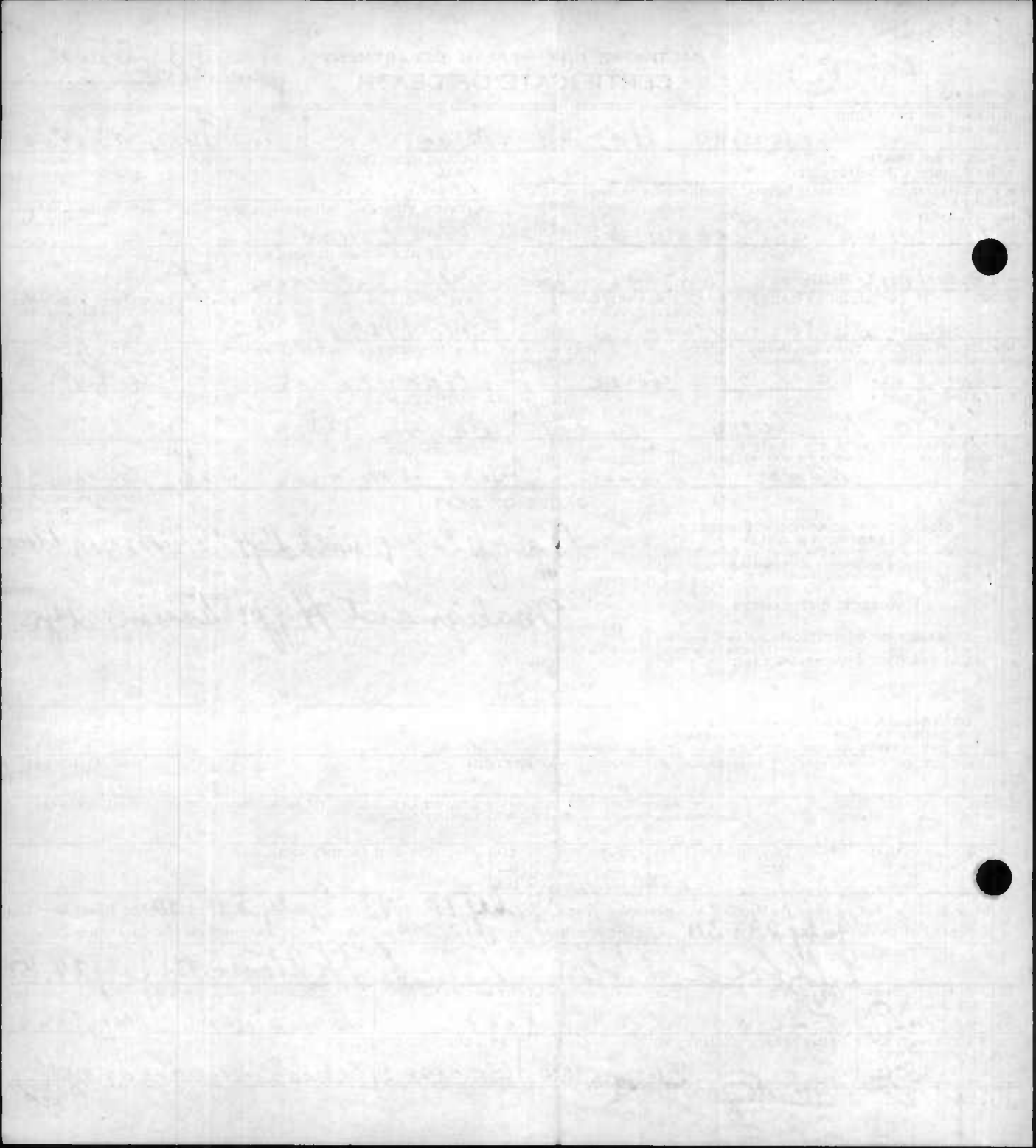
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6466  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>LILLIAN HAZEL MORRISON</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>446 S. FURROW ST</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>BALTIMORE 20-05</b>	
C. Length of stay in Baltimore <b>35 YRS</b>		D. STREET ADDRESS (If rural, give location) <b>446 S. FURROW ST.</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>Sept. 14, 1897</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	9. AGE (In years last birthday) <b>52</b> If Under 1 Year Months: Days: Hours: Min.
13. FATHER'S NAME <b>FRANK TOMS</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE P.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>John H. Morrison</b>		ADDRESS <b>446 S. FURROW ST.</b>	
18. <b>334X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Apoplexy with Left HEMIPLEGIA</b> DUE TO <b>Malignant Hypertension</b> DUE TO <b>2 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 Hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>July 10, 1948</b> to <b>July 23, 1950</b> that I last saw the deceased alive on <b>July 23, 1950</b> and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above.			
23A. SIGNATURE <b>Alfred Cole</b>		23B. ADDRESS <b>136 S. Hilton St.</b>	
23C. DATE SIGNED <b>July 24, 50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>7-26-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 24 1950</b>	REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>George L. Schwab</b>	
		ADDRESS <b>2101 Frederick Ave.</b>	

MEDICAL CERTIFICATION

83a





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6467**

BIRTH NO. **516**

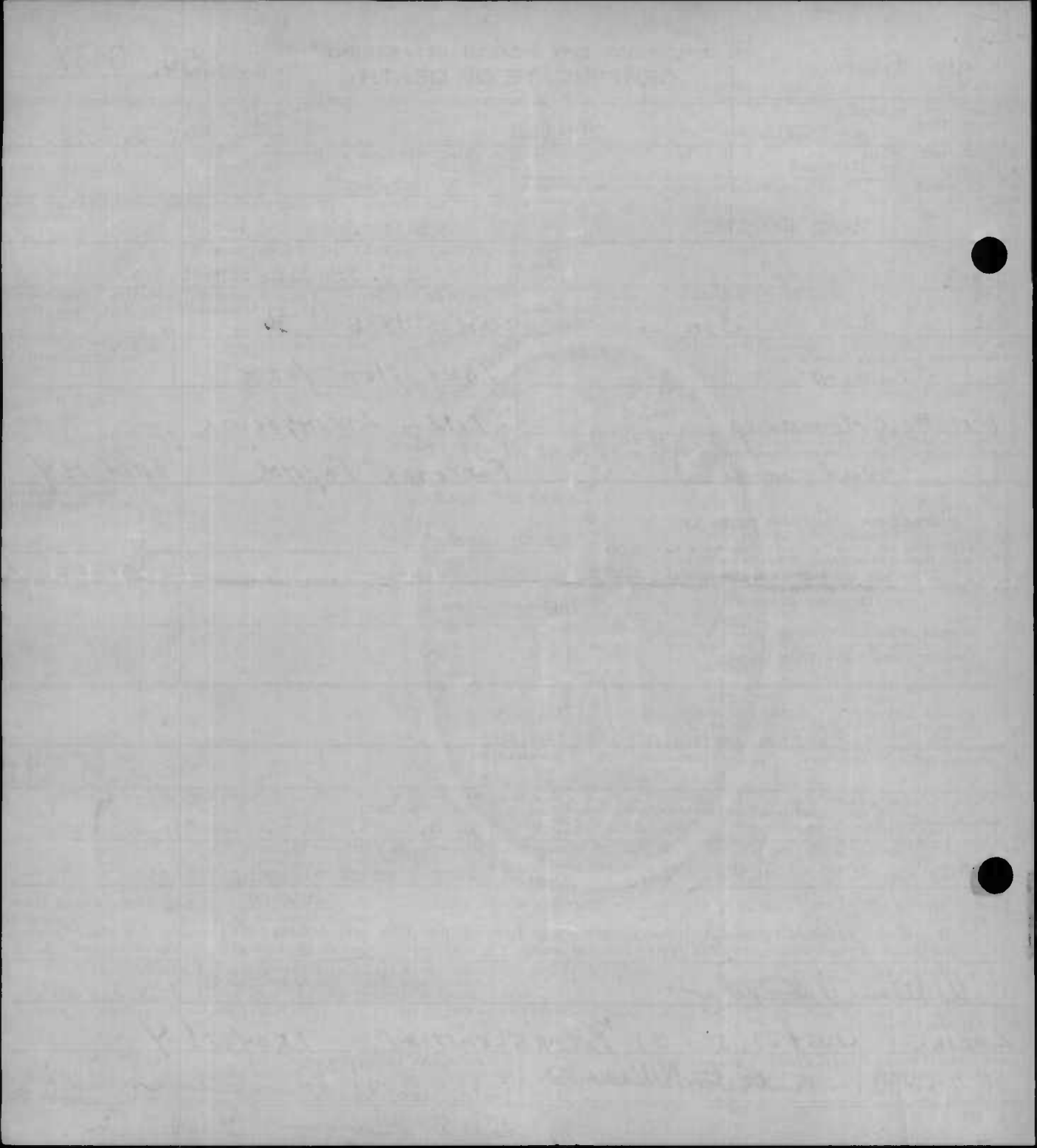
1. NAME OF DECEASED (Type or Print) <b>WILLIAM CHAMBERS</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>11-02</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>24 W. Franklin Street</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>JAN. 5 1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>34</b> 11 Under 1 Year Months Days 12 Under 24 Hours Min.
13. FATHER'S NAME <b>WM. F. CHAMBERS</b>		11. BIRTHPLACE (State or foreign country) <b>TROY NEW YORK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>World War 2</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>ETHEL LIVINGSTOCK</b>	
17. INFORMANT <b>FLORENCE FLYNN</b>		ADDRESS <b>TROY N. Y.</b>	

18. <b>E 970.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute alcoholism</b> (A) <b>Acute alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Barbiturate poisoning</b> (B) <b>Barbiturate poisoning</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Public building</b>		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Y. M. C. A., 24 W. Franklin Street 11/2</b>	
21d. TIME (Month) (Day) (Year) (Hour) <b>July 23, 1950 12:05 A. M.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Ingestion of sleeping tablets</b>	

22. I certify that I took charge of the remains described above, held an **Autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

23a. SIGNATURE <b>William V. ...</b>		23b. CHIEF MEDICAL EXAMINER..... M.D. MEDICAL INVESTIGATOR.....		23c. DATE SIGNED <b>July 24, 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>JULY 27, 50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER'S CEMETERY</b>	
24d. LOCATION (City, town, or county) (State) <b>TROY N. Y.</b>		25. FUNERAL DIRECTOR <b>Ellsworth Annacast</b>		ADDRESS <b>163 B</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>		5118 <b>Shannon Oaks Ave</b>	



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50 6468

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

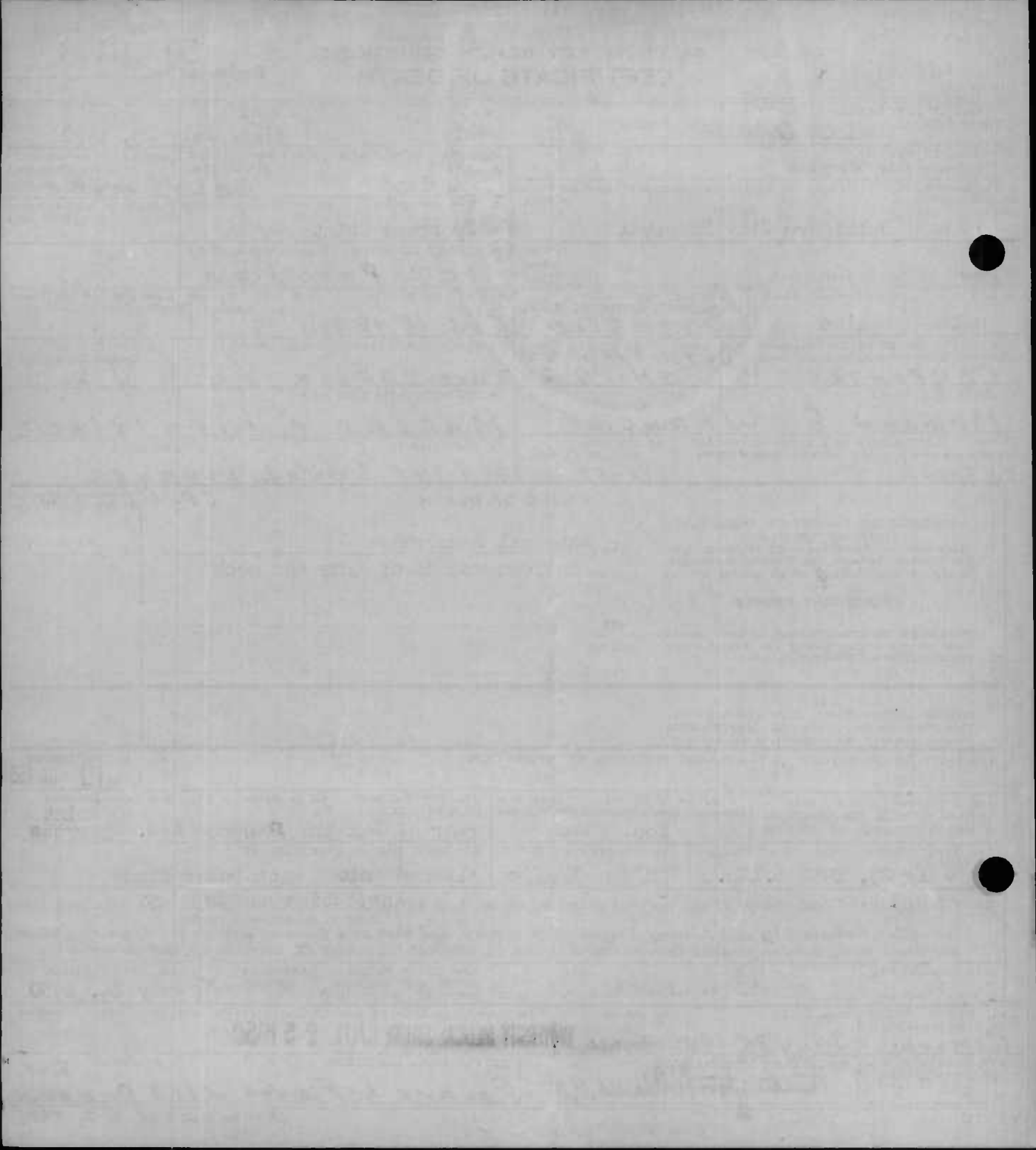
50 6468  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>MADISON D. WARNER</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: a. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>BALTIMORE</b>	
b. FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Sparrows Point</b>	
c. Length of stay in Baltimore		d. STREET ADDRESS (If rural, give location) <b>Box 316 Penwood Avenue</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>FEB. 18, 1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BETH-STEEL INDUSTRY SHIPYARD</b>	9. AGE (In years last birthday) <b>59</b>
11. BIRTHPLACE (State or foreign country) <b>THAMSBROOK, VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>MADISON F. WARNER</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET LICKLEIDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>213-07-8522</b>	
17. INFORMANT <b>MRS. EDNAH WARNER</b>		ADDRESS	

18. <b>E977X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>External hemorrhage</b> DUE TO <b>incised wounds of arms and neck</b>		INTERVAL BETWEEN ONSET AND DEATH <b>SP. PT. 1/2</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>tool shed</b>		21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Point rear of Box 316 Penwood Ave. Sparrows</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>July 23, 1950 6.15p. m.</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>slashed arms with razor blade</b>	
22. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23a. SIGNATURE <b>Stanley V. Dineacher</b> M.D.		23b. CHIEF MEDICAL EXAMINER..... <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input type="checkbox"/>		23c. DATE SIGNED <b>July 24, 1950</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>JULY 25, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>UNIVERSITY MEDICAL SCHOOL</b>	
24d. LOCATION (City, town, or county) (State) <b>JUL 25 1950</b>		25. FUNERAL DIRECTOR <b>ROLAND L. FISHER</b>		ADDRESS <b>2112 DUNDALK</b>	

MEDICAL CERTIFICATION



BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATHRegistered No. 50 6469

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)Charles Joseph Ulrich2. DATE  
OF  
DEATHJuly 24, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland 771 W. Cross St

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

771 W. Cross St.

c. Length of stay in Baltimore

LifeYrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)male WhiteWidowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

MachinistN. Enameling & Stamp

13. FATHER'S NAME

Charles Joseph Ulrich

11. BIRTHPLACE (State or foreign country)

Baltimore - Md.12. CITIZEN OF  
WHAT COUNTRY?

14. MOTHER'S MAIDEN NAME

Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)no16. SOCIAL  
SECURITY NO.215-03-3071A

17. INFORMANT

ADDRESS

Regina M. Ulrich 771 W. Cross St18. 443X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiac Vasc. disease unkm.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Heart block

DUE TO

1 mth.

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐22. I hereby certify that I attended the deceased from July 14, 1950, to July 24, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Charles Lombardo

M. D.

910 W. Lombard StJuly 24/5024A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

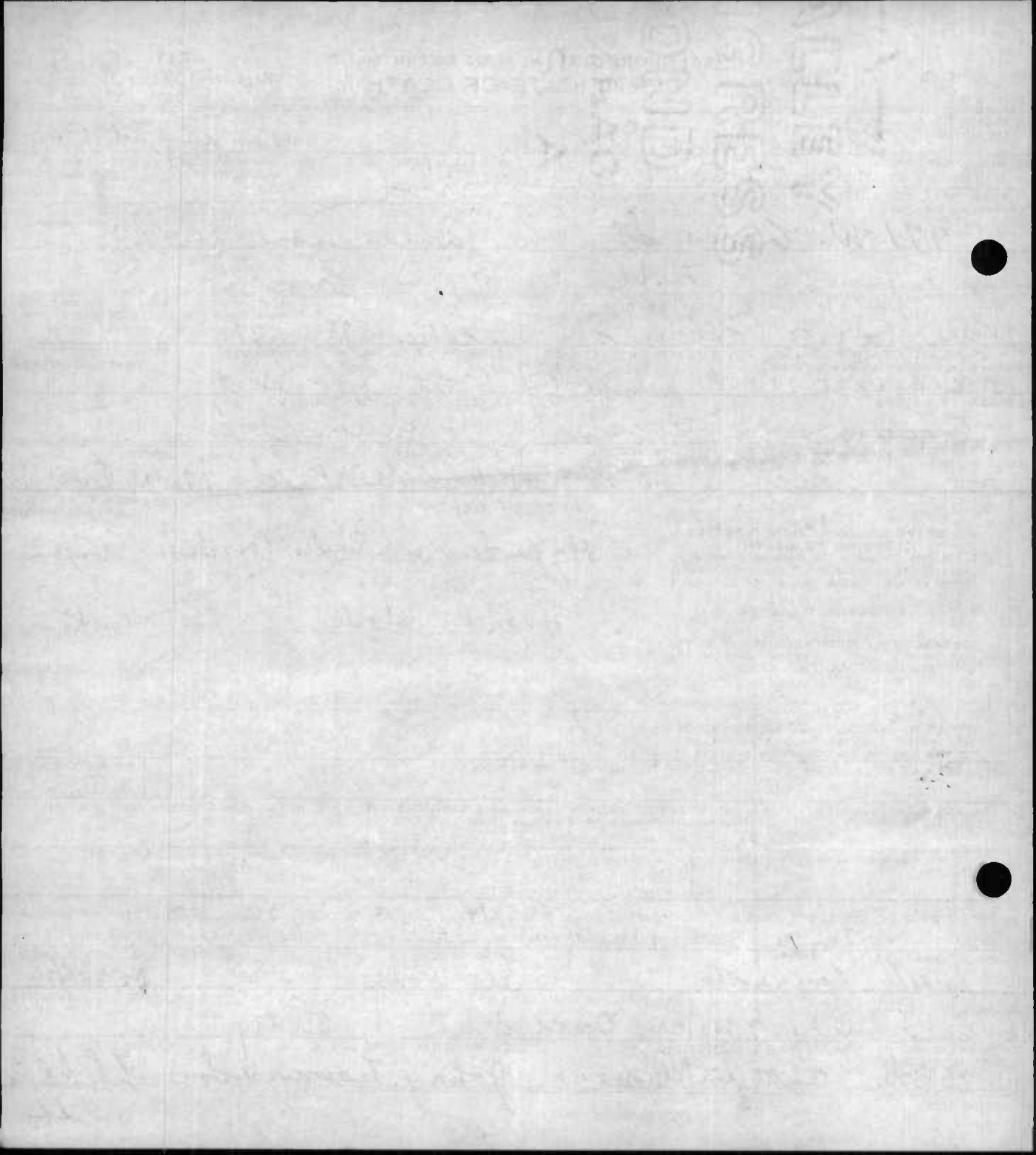
ADDRESS

JUL 25 1950Wilmington Williams, M.D.John J. Lowan & Son2401 St.

VS 150

54430

931 St.





0.00

50 6470

# Foy

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

 50 6470  
 Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <i>William Foy, Sr.</i>		2. DATE OF DEATH <i>7-24-50.</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>City</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____	
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>1303 Harrow Court</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore 25-06</i>	
C. Length of stay in Baltimore <i>26</i> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>1303 Harrow Court</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>Sept. 23, 1898</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Leader, Bethlehem Shipyard.</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>51</i> 10. Under 1 Year Months: <i>10</i> Days: <i>1</i> 11. Under 24 Hours Hours: _____ Min. _____
11. BIRTHPLACE (State or foreign country) <i>Edenton, N. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Joseph Foy</i>		14. MOTHER'S MAIDEN NAME <i>Victoria Wilkens</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-03-9942</i>	
17. INFORMANT <i>William Foy Jr.</i>		ADDRESS <i>636 N. Carey St.</i>	

18. <i>443 X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  DUE TO <i>Acute Nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 Weeks</i>
ANTECEDENT CAUSES  DUE TO <i>Hypertensive Heart Disease</i>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  DUE TO <i>Cardiac Decompensation</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

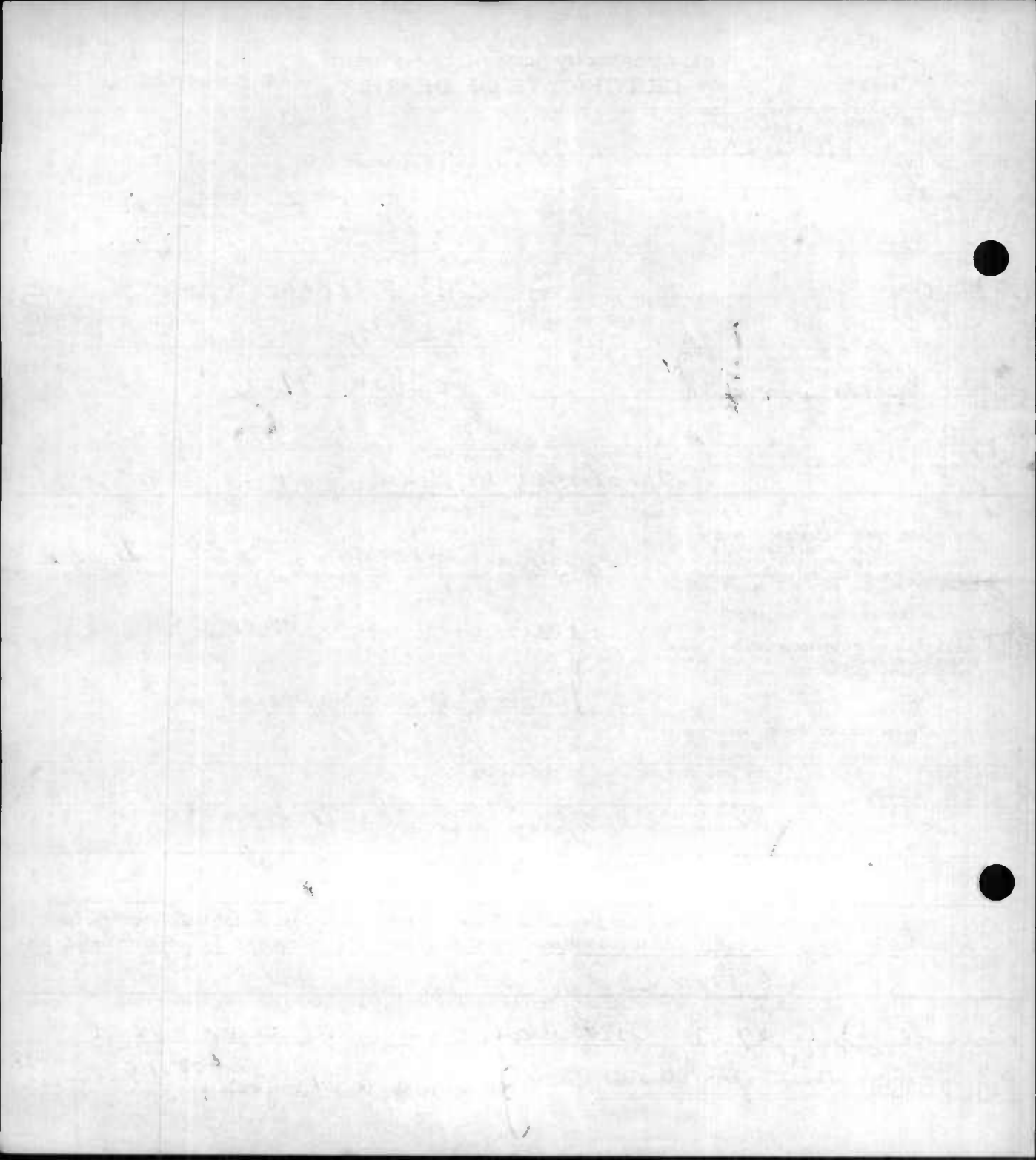
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *March 1, 1950*, to *July 23rd, 1950*, that I last saw the deceased alive on *July 23, 1950*, and that death occurred at *2:15 A.M.*, from the causes and on the date stated above.

23A. SIGNATURE <i>James B. Luck</i>		23B. ADDRESS <i>427 Swale Ave</i>		23C. DATE SIGNED <i>7-24-50</i>	
--	--	--------------------------------------	--	------------------------------------	--

24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 27 50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Int Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>a. a. co. Md</i>	
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DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 25 1950</i>		REGISTRAR'S SIGNATURE <i>Thurston Williams, M.D.</i>		25. FUNERAL DIRECTOR <i>James A. Stokes</i>		ADDRESS <i>638 N. 9th St</i>	
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43

LEOPOLD

50 6471

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6471

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Poland D. Leopold</b>		2. DATE OF DEATH <b>7/23-50</b>	
3. PLACE OF DEATH A. Baltimore City, Maryland <b>223 E Lafayette Ave</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto Md 12-05</b>	
6. Length of stay in Baltimore <b>1 1/2</b> Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>2/25/1902</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		9. AGE (In years last birthday) <b>48</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Carlinway Co</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>	
13. FATHER'S NAME <b>Horatio Leopold</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>Sarah Leopold</b>	
16. SOCIAL SECURITY NO. <b>212-01-5416</b>		17. INFORMANT <b>Sarah Leopold</b>	

18. **162X**  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

**Brophrogenic Carcinoma**

INTERVAL BETWEEN ONSET AND DEATH

**12 mo**

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION <b>Feb 1950</b>	19B. MAJOR FINDINGS OF OPERATION <b>Brophrogenic Carcinoma, Inoperable</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (a. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE <input type="checkbox"/> AT WORK	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Aug 3, 1949**, to **July 23, 1950**, that I last saw the deceased alive on **July 21, 1950** and that death occurred at **9:45 A.M.**, from the causes and on the date stated above.

23A. SIGNATURE <b>William F. Pearce</b>	23B. ADDRESS <b>2105 N Charles St</b>	23C. DATE SIGNED <b>July 24, 1950</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/26/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
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DATE RECEIVED BY LOCAL REGISTRY <b>JUL 25 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Chas P. Towell</b>	ADDRESS <b>2427 Edmondson Ave</b>
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Box for  
105 N Charles St  
L 1552

621

HARISBERG

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6472

Registered No.

1. NAME OF DECEASED (Type or Print) <i>Annie L. Harisberg</i>		2. DATE OF DEATH <i>July 24/1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>802 E 33rd St.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>	
c. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>802 E 33rd St.</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>Dec 18/1858</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>91</i>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Schmincke</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>Y</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Helen Thomas</i>		ADDRESS <i>726 E 33rd St.</i>	
18. <i>442X</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) <i>Hypertension in cardio-vascular disease.</i> DUE TO ANTECEDENT CAUSES (B) _____ DUE TO (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <i>several years</i>
19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 1</i> , 19 <i>50</i> , to <i>July 24</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>July 24</i> , 19 <i>50</i> , and that death occurred at <i>527</i> m., from the causes and on the date stated above.			
23A. SIGNATURE <i>E. S. Syfer</i>		23B. ADDRESS <i>426 S. Patterson Park</i>	
M. D. <i>July 26/1950</i>		23C. DATE SIGNED <i>7/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>July 26/1950</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Lundown Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 25 1950</i>		REGISTRAR'S SIGNATURE <i>Winston Williams, M.D.</i>	
25. FUNERAL DIRECTOR <i>Annie L. Syfer</i>		ADDRESS <i>1600 N. Hawthorne Ave.</i>	

MEDICAL CERTIFICATION

131a

See Ledger

426 St Patterson Plc Ave



530  
50 6473  
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6473  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Frank Bennett</b>		2. DATE OF DEATH <b>July 23 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>Baltimore Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Nova Scotia</b> B. COUNTY <b>V-50</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Sidney</b>	
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>562 Victoria Road</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>about 1911</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>able Seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Ship Industry Atlantic Agency, Ltd.</b>	9. AGE (In years last birthday) <b>39</b>
11. BIRTHPLACE (State or foreign country) <b>Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>British Consulate, Garrett Building</b>		ADDRESS	

18. <b>E929.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Drowning</b> (A) _____ DUE TO _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO _____		
(C) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>July 23, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Harbor</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Harbor</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Water at foot of Broadway 2-3</b>	
21D. TIME (Month) (Day) (Year) (Hour) <b>July 23, 1950 1:00 A. m.</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Found drowned</b>	
22. I certify that I took charge of the remains described above, held an <b>Autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input checked="" type="checkbox"/> .					
23A. SIGNATURE <b>William V. ...</b>		23B. CHIEF MEDICAL EXAMINER..... M.D. ASSISTANT MEDICAL EXAMINER..... MEDICAL INVESTIGATOR.....		23C. DATE SIGNED <b>July 23, 1950</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>7/25/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		24E. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>		24F. REGISTRAR'S SIGNATURE <b>William V. ...</b>	
24G. FUNERAL DIRECTOR <b>Wm. Cook, Inc.</b>		24H. ADDRESS <b>1217 St. Paul Street</b>		24I. DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>	

CENTRAL OFFICE OF DEATHS

Quarantine

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6474  
Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>Arthur P. Hoffman</b>			2. DATE OF DEATH <b>July 22 1950</b>		
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland 3639 Pulaski Highway</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY _____		
B. FULL NAME OF HOSPITAL OR INSTITUTION _____			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 26-44</b>		
c. Length of stay in Baltimore <b>40 Yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>3639 Pulaski Highway</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 14 1903</b>		9. AGE (In years, last birthday) <b>47</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watch Repair</b>		10B. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Chicago Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Charles Hoffman</b>			14. MOTHER'S MAIDEN NAME <b>Anita Doyle</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <b>Rose M. Di Labio 3639 Pulaski Highway</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <b>Coronary Thrombosis</b> DUE TO (B) <b>Hypertensive Cardiovascular Disease</b> DUE TO (C) <b>Hypertension</b>	INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
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19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) _____		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME (Month) (Day) (Year) (Hour) INJURY _____		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>July 20, 1950</b> , to <b>July 22, 1950</b> , that I last saw the deceased alive on <b>July 21, 1950</b> , and that death occurred at <b>7:30 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>John Constantine</b>		23B. ADDRESS <b>234 S. Lombard St.</b>		23C. DATE SIGNED <b>7-24-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 22 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>4430 Belair Rd. Balt. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>III 25 1950</b>		REGISTRAR'S SIGNATURE <b>Huntington Williams, M.D.</b>		25. FUNERAL DIRECTOR <b>Frank D. Della Croce</b>		ADDRESS <b>322 S. High St.</b>	

6903 Y

93D

MEDICAL CERTIFICATION

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

256

50 6475

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6475

BIRTH NO. 50-05021

1. NAME OF DECEASED  
(Type or Print)

Henry F. Wiesner, 4th

2. DATE

OF DEATH July 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

13 Mallow Hill Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE MarylandC. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Baltimore 28-04

D. STREET ADDRESS (If rural, give location)

13 Mallow Hill Avenue

c. Length of stay in Baltimore Life

Yrs.  
Mos.  
Days

5. SEX

male

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

March 17, 1950

9. AGE (In years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours Min.

4 6

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry F. Wiesner

14. MOTHER'S MAIDEN NAME

Betty E. Rhoades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Henry F. Wiesner, 13 Mallow Hill Ave

18. 754.4 I

## CAUSE OF DEATH

Catoxville INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fibro-elastosis of endocardium and myocardium

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE

William V. Wood

23B. CHIEF MEDICAL EXAMINER.....

23C. DATE SIGNED

M.D.

ASSISTANT MEDICAL EXAMINER.....

July 24, 1950

MEDICAL INVESTIGATOR.....

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

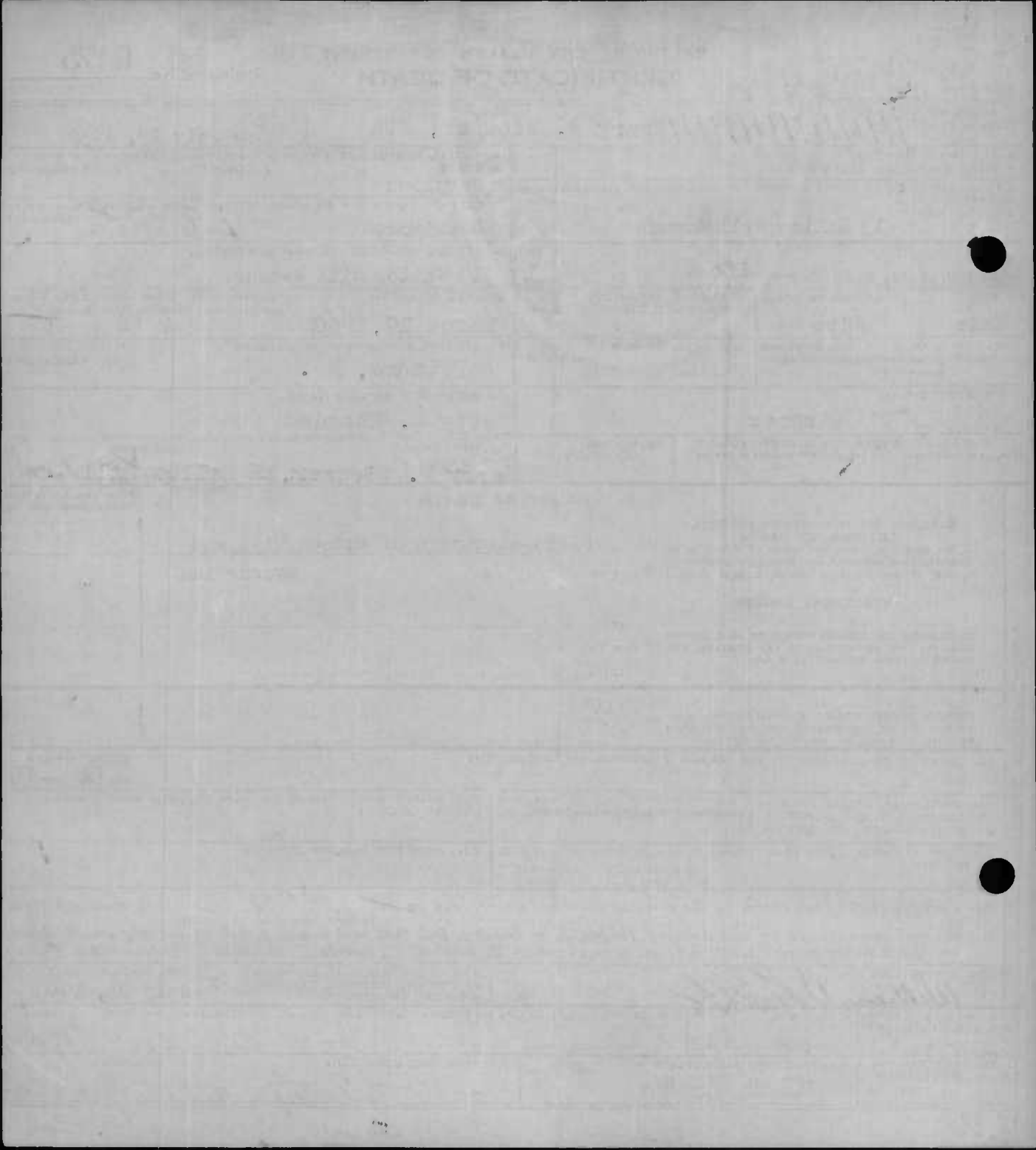
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

VS 151

157E Ave





530

50 6476

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

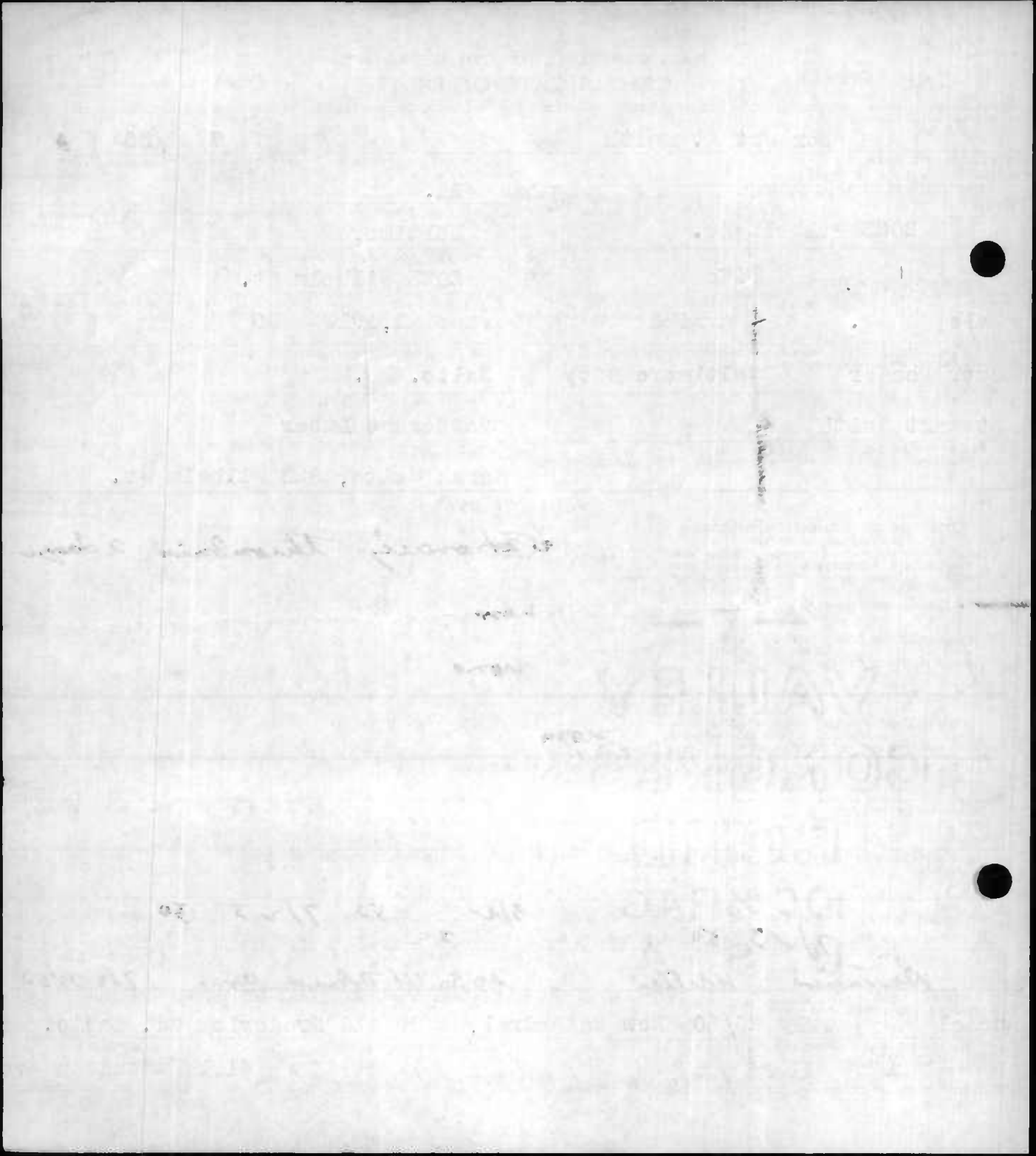
Registered No. 50 6476

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Norbert A. Smith</b>		2. DATE OF DEATH <b>7/23/50</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>2023 Wilhelm St.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>20-03</b>			
c. Length of stay in Baltimore <b>Life</b>		D. STREET ADDRESS (If rural, give location) <b>2023 Wilhelm St.</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>June 21, 1910</b>	9. AGE (In years last birthday) <b>40</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meter Reader</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
13. FATHER'S NAME <b>Stewart Smith</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Lubber</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Sarah Smith, 2023 Wilhelm St.</b>	

18. <b>420.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>none</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>none</b>		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>3/2</b> , 19 <b>50</b> to <b>7/23</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7/23</b> , 19 <b>50</b> , and that death occurred at <b>3 a</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Benjamin M. Miller</b>		23B. ADDRESS <b>2030 W. D. Ave</b>		23C. DATE SIGNED <b>7/24/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 26/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>4300 Old Frederick Rd. Balto. Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>50L 20-0300</b>		REGISTRAR'S SIGNATURE <b>Wilmington Williams</b>		25. FUNERAL DIRECTOR <b>Harry A. Witzke</b>		ADDRESS <b>4101 Edmondson Ave</b>	



520

50 6477

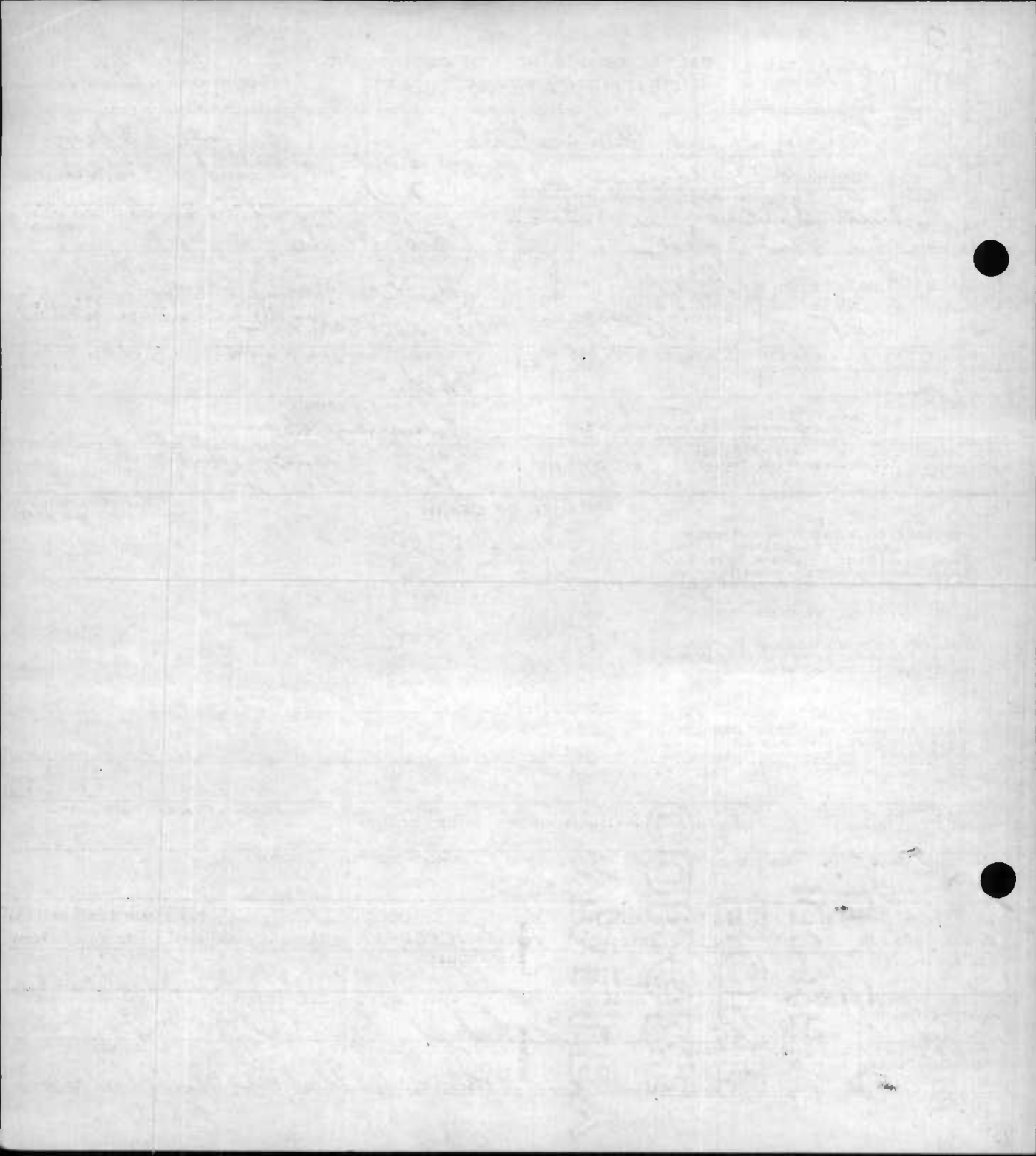
Reineke  
BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 6477

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Elizabeth Reineke</i>		2. DATE OF DEATH <i>July 23/50</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i>			
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTION) <i>Little Sisters of the Poor Home for the aged</i>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Catonville</i>			
C. Length of stay in Baltimore <i>Life</i>		D. STREET ADDRESS (If rural, give location) <i>101 Montrose Ave</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>W.</i>	8. DATE OF BIRTH <i>Feb. 28, 1865</i>		9. AGE (In years last birthday) <i>85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>Anthony Wucher</i>		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sister Synthesis</i> ADDRESS <i>1200 Valley St.</i>	

18. <i>472.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 23, 1949</i> to <i>July 23, 1950</i> , that I last saw the deceased alive on <i>July 22, 1950</i> , and that death occurred at <i>4:50 P. M.</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Carol Fisher</i>		23B. ADDRESS <i>1823 N. Wash. St.</i>		23C. DATE SIGNED <i>7/25/50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>7/26/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>	
24D. LOCATION (City, town, or county) <i>Balto Md</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 25 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wilmington Williams</i>	
24G. FUNERAL DIRECTOR <i>Harvey H. Weyke</i>		24H. ADDRESS <i>4101 Calmon Ave</i>			



350

50 6478

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6478

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Ida M. Madden

2. DATE  
OF  
DEATH

7-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

B. COUNTY

before admission)

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4700 Harford Rd.

C. CITY OR TOWN

Maryland  
Baltimore

27-02

(If outside corporate limits, write RURAL and give township)

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

D. STREET ADDRESS (If rural, give location)

2409 Arlington Ave

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

If Under 1 Year

If Under 24 Hours

Months: Days

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22. I hereby certify that I attended the deceased from Sept. 1949, 19, to July 22, 1950, that I last saw the deceased alive on July 22, 1950, and that death occurred at 6 a.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Karl Traupitz

M.D.

1623 E. N. Avenue

7/24/50.

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 25 1950

Huntington Williams

L. J. Luck - 5305 7 Harford Rd.

Dr. Tragott  
1623 E. North Ave



436  
435  
50

6479

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6479  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Nellie Golder Or Golden</b>		2. DATE OF DEATH <b>July 22 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland Balto. City</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore City</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>836 North Carey Street</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore City</b>	
c. Length of stay in Baltimore <b>60 Yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>836 North Carey Street</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 30 1883 67</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (State or foreign country) <b>Hoode Mills Howard Co Md U.S.A.</b>
13. FATHER'S NAME <b>Joseph Hardy</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Berry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215.01.3925.A</b>	
		17. INFORMANT <b>Elmer N. Hardy</b>	
		ADDRESS <b>1042 Brantly Ave</b>	

18. <b>334X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Central Apoplexy &amp; Paralysis</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7/21 1950</b> , to <b>7/22 1950</b> , that I last saw the deceased alive on <b>7/22 1950</b> and that death occurred at <b>5:00 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>B. M. R. H. H.</b>		23B. ADDRESS <b>2139 2nd Ave</b>		23C. DATE SIGNED <b>7-25-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/26/1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt Arburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>		25. FUNERAL DIRECTOR <b>Thos. Wilson</b>		ADDRESS <b>1000 Brantly Ave</b>	

VALLEY  
COMMONS  
BOND

612

50 6480

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6480

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CARL HOTOR HAUERBACH

2. DATE  
OF  
DEATH

23 JULY 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

UNION MEMORIAL HOSPITAL

Yrs.  
Mos.  
Days

C. Length of stay in Baltimore 30 yrs

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

representative

10B. KIND OF BUSINESS OR  
INDUSTRY

shipping co.

13. FATHER'S NAME

MARGWARD HAUERBACH

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

132-03-2241

17. INFORMANT

MRS. C.H. HAUERBACH

ADDRESS

1112 RAMBLEWOOD RD.  
BALT. 12, MD.

18. 151X 1

## CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Pulmonary Embolism

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

30 min.

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Carcinoma of Stomach

?

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

July 8, 1950

19B. MAJOR FINDINGS OF OPERATION

Carcinoma of Stomach

20. AUTOBIO?

YES ☒ NO ☐21. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e.g., in or  
about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ WORK NOT WHILE ☐ AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 8, 1950, to July 23, 1950, that I last saw the  
deceased alive on July 23, 1950, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

23A. SIGNATURE

Alvin Bonfleur

M. D.

23B. ADDRESS

Union Memorial Hosp

23C. DATE SIGNED

July 23, 1950

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

cremation

24B. DATE

7/25/50

24C. NAME OF CEMETERY OR CREMATORY

Greenmount Crematory

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Wilmington Williams, M.D.

25. FUNERAL DIRECTOR

HENRY SANDER & SONS, INC.  
BALTO., MD.

ADDRESS

George J. Sander

VS 150

3005570

46B

MEDICAL CERTIFICATION

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

Washington, D. C.  
June 1, 1907  
Dear Sir:  
I have the honor to acknowledge the receipt of your letter of May 21, 1907, in relation to the matter of the exportation of certain plants from the United States.

I am sorry to hear that you are having trouble with the plants. I have been very busy lately, but I will try to get some information for you as soon as possible. I will also try to get some information for you as soon as possible.

I am, Sir, very respectfully,  
Yours very truly,  
J. H. ...  
Special Agent in Charge

550

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6481

BIRTH NO. 50 6481

1. NAME OF DECEASED  
(Type or Print)

SOLOMON I HYMAN

2. DATE  
OF  
DEATH

7-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE

B. COUNTY

Md

B. FULL NAME OF (If not in hospital or institution, give street address or location)

3004 No Helton St

C. CITY OR TOWN

(If outside corporate limits, write FULLAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3004 No Helton St

c. Length of stay in Baltimore

50 Yrs. Mos. Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

62

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

10B. KIND OF BUSINESS OR INDUSTRY

Millinery

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Not known

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Julian Hyman - Same

18. 592X CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis -

DUE TO

Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Nephritis

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

6 hrs

5 yrs

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bronchitis - (marked) Related

13 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)

INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1921 to July 24, 1950 that I last saw the deceased alive on July 24, 1950 and that death occurred at 11:00 p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

Joseph W. Katzky - M. D.

11 E. Chase St. Balto - 2

7/25/50

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

JUL 25 1950

Thurston Williams, M.D.

Jack Lewis Inc

2100 Eutaw St

VS 150

2906E

131a

MEDICAL CERTIFICATION

Kenny  
118 Chase St  
HAM



430

50 6482

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6482  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JACOB I PHEET

2. DATE  
OF  
DEATH

7-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

4300 Pulver Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

4300 Pulver Road

c. Length of stay in Baltimore

46

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

B. DATE OF BIRTH

9. AGE (in years  
last birthday)

63

10. Under 1 Year  
Months Days11. Under 24 Hours  
Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Tailor

10B. KIND OF BUSINESS OR INDUSTRY

self

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Samuel

14. MOTHER'S MAIDEN NAME

Tony

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

Samuel Pleet 3729 Park Hyatt Ave

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertension - Arteriosclerosis

INTERVAL BETWEEN  
ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDER-  
LYING ☐ OR CONTRIBUTING ☐  
CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour)  
INJURY

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1950, to July 24, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 11:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE

Daniel J. Schvartz

M. D.

23B. ADDRESS

2320 Eutaw Place

23C. DATE SIGNED

7-25-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

24B. DATE

7-25-50

24C. NAME OF CEMETERY OR CREMATORY

Hebrew Acacia Hill

24D. LOCATION (City, town, or county)

Baltimore

(State)

Md

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Trustington Williams, Jr.

25. FUNERAL DIRECTOR

Jack Lewis

ADDRESS

2100 Eutaw Pl

JUL 25 1950

5906E 481

93c

MEDICAL CERTIFICATION

Schwartz  
73rd  
Gatow PL

520

50 6483

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6483

1. NAME OF DECEASED (Type or Print) CLARA E. THOMAS		2. DATE OF DEATH July 24, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-02	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 4232 Seidel Avenue	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Mar 4, 1891
		9. AGE (In years last birthday) 58	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10B. KIND OF BUSINESS OR INDUSTRY Emerson Drug Co	11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles F. Schmidt	
14. MOTHER'S MAIDEN NAME Minnie Schmidt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT John Thomas Jr 4232 Seidel Ave	

18. E974X

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation by hanging

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4232 Seidel Avenue
21D. TIME (Month) (Day) (Year) (Hour) July 24, 1950 11:15 A. m.	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? Hanged self by clothes line from water pipe in cellar

22. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐.

23A. SIGNATURE Stanley H. Dendacher M.D.	23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>	23C. DATE SIGNED July 24, 1950
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	24B. DATE 7/27/50	24C. NAME OF CEMETERY OR CREMATORY Woodland Memorial
24D. LOCATION (City, town, or county) (State) Baltimore	24E. FUNERAL DIRECTOR Medford J. Blight 6009 Bayford	

DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1950	REGISTRAR'S SIGNATURE Huntington Williams, M.D.	25. FUNERAL DIRECTOR Medford J. Blight 6009 Bayford
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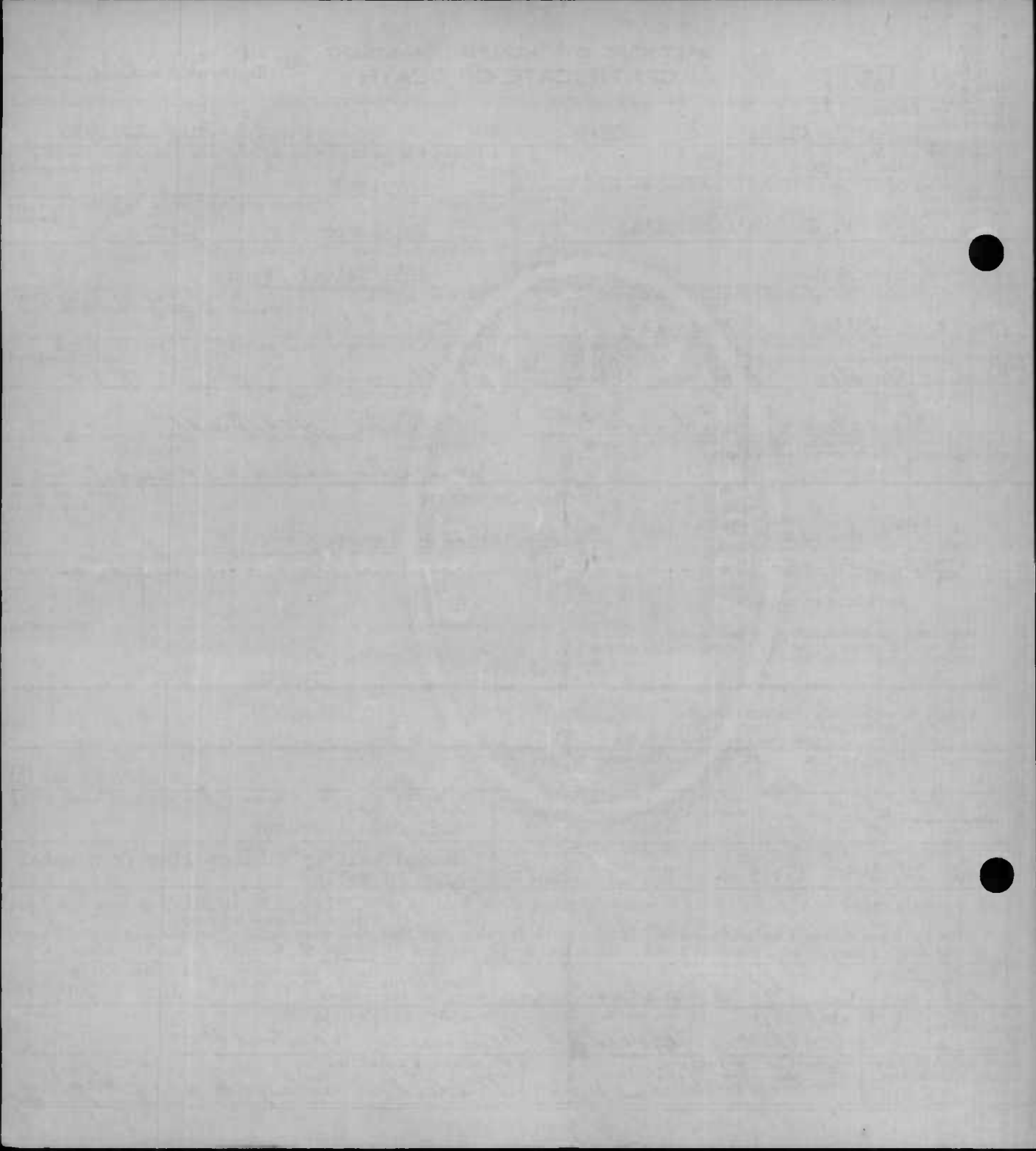
VS 151

N 991X

6904P

164a

MEDICAL CERTIFICATION



535

50 6484

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6484  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Amelia Sondheim</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b> <b>Balto. Md.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Revera Apts. Lake Dr. &amp; Linden Ave.</b>		C. CITY OR TOWN (If outside corporate limits, state rural and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>83 yrs.</b>		D. STREET ADDRESS (If rural, give location) <b>Lake Dr. &amp; Linden Ave.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>July 12, 1867</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>83</b>
13. FATHER'S NAME <b>Woolf Stern</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>David Sondheim Lake Dr. &amp; Linden Ave.</b>	

18. <b>450.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>General Arterio. Sclerosis</b> DUE TO	CAUSE OF DEATH <b>General Arterio. Sclerosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Senility</b> DUE TO	<b>Senility</b>	<b>3 yrs</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME (Month) (Day) (Year) (Hour) INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 1945</b> , to <b>July 23, 1950</b> , that I last saw the deceased alive on <b>July 22, 1950</b> , and that death occurred at <b>3 12</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>Emilio J. ...</b>		23B. ADDRESS <b>The Explorers 17</b>		23C. DATE SIGNED <b>7/24/50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>July 26, 1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>		REGISTRAR'S SIGNATURE <b>Washington Williams, M.D.</b>	25. FUNERAL DIRECTOR ADDRESS <b>David R. Martin 1902 Eutaw Pl.</b>

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DECEASED

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF MINISTER

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF COURT

SIGNATURE OF STATE

SIGNATURE OF NATION

SIGNATURE OF WORLD

SIGNATURE OF UNIVERSE

SIGNATURE OF GOD

SIGNATURE OF HEAVEN

SIGNATURE OF EARTH

SIGNATURE OF WATER

SIGNATURE OF FIRE

SIGNATURE OF AIR

SIGNATURE OF LIGHT

SIGNATURE OF DARKNESS



650

50 6485

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6485

BIRTH NO. *H-90594*1. NAME OF DECEASED  
(Type or Print)*MARCIA BROWN*2. DATE  
OF  
DEATH*7/23/50*

3. PLACE OF DEATH:

A. Baltimore City, Maryland *University Hosp.*B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION*University Hospital*  
*all floor*

C. Length of stay in Baltimore

Yrs.  
Mos.  
Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

C. CITY OR TOWN

(If outside corporate limits, give RURAL and give township)

D. STREET ADDRESS (If rural, give location)

*1608 N. Calver St.*

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)8. DATE OF BIRTH *2/10/1924* AGE (In years, Months, Days) *26 yrs. 5 mos. 13 days*

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

*Edward Brown*

14. MOTHER'S MAIDEN NAME

*Ruth Brown*

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

*Father**1608 N. Calver St.*18. *E 885.0*

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

## CAUSE OF DEATH

(3) *Lead Encephalopathy*

DUE TO

(1) *Cerebral edema + petechiae*

(B)

DUE TO

(2) *Acute, Chronic*

(C)

*Toxidity, Cardiac failure*

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

*Joseph B. Brown* M.D.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)  
*accident*21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
*Home*21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  
*1608 N. Calver St. 15/1*21D. TIME (Month) (Day) (Year) (Hour) OF INJURY  
*July 21, 1950 ? ? m.*21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

*Falling window sill*22. I hereby certify that I attended the deceased from *7/21*, 1950, to *7/23*, 1950, that I last saw the deceased alive on *7/23*, 1950, and that death occurred at *7* p.m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

*Joseph B. Brown* M.D.*University Hospital**7/24/50*

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

*Jul 25 1950**Thurston Williams, M.D.**Geo. B. Nelson 1303 Resatman St.*

VS 150

*N-966-0**78B*

MEDICAL CERTIFICATION

9-90594

520

50

6486

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

50

6486

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Howard

Young

2. DATE  
OF  
DEATH

July 23, 1950

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR  
INSTITUTION

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence  
A. STATE B. COUNTY before admission)

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

3-01

D. STREET ADDRESS (If rural, give location)

39 S. Bond St.

C. Length of stay in Baltimore

Life

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

7/17/1894

9. AGE (In years  
last birthday)

56

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

uffeur

10B. KIND OF BUSINESS OR  
INDUSTRY

Trucking Co.

11. BIRTHPLACE (State or foreign country)

Baltimore Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William C. Ball

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

unknown

16. SOCIAL  
SECURITY NO.

218-10-2257

17. INFORMANT

ADDRESS

Sarah Young-228 Bethel Court

18. E 983 X I

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Skull fracture with laceration of brain

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐21A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)

Home---

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

228 Bethel Court (wife's Home,

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

July 23, 1950 3 P. M.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Blunt force-Hit with baseball bat

22. I certify that I took charge of the remains described above, held an Autopsy-Partial thereon and from  
Autopsy, Inspection or Inquiry  
the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above,  
and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

23A. SIGNATURE

William V. Smith

23B. CHIEF MEDICAL EXAMINER.....☐

23C. DATE SIGNED

ASSISTANT MEDICAL EXAMINER.....☒

July 24, 1950

M.D. MEDICAL INVESTIGATOR.....☐24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

7/27/50

24C. NAME OF CEMETERY OR CREMATORY

Mt Auburn, Ct.

24D. LOCATION (City, town, or county)

Baltimore City

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

108-W

ADDRESS

J. L. Brown &amp; Son - Montgomery St.

*[Faint handwritten notes at the bottom of the page]*

420  
50 6487

CERTIFICATE CORRECTED 7-25-50

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6487  
Registered No.

1. NAME OF DECEASED (Type or Print) <i>William G. Helis</i>		2. DATE OF DEATH <i>JUL 25 1950</i>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>La.</i> B. COUNTY <i>V-16</i>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <i>JOHNS HOPKINS HOSPITAL</i>		C. CITY OR TOWN <i>New Orleans</i>	
6. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <i>27 Audobon Pl.</i>	
7. SEX <i>male</i>	8. COLOR OR RACE <i>white</i>	9. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>M.</i>	10. DATE OF BIRTH <i>Oct. 17, 1886</i>
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Producer of Crude Oil</i>		12. AGE (In years last birthday) <i>63</i>	
13. FATHER'S NAME <i>George Helis</i>		14. BIRTHPLACE (State or foreign country) <i>Greece</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>yes</i>		16. SOCIAL SECURITY NO.	
17. MOTHER'S MAIDEN NAME <i>Mary Stasinopoulos</i>		18. CITIZEN OF WHAT COUNTRY?	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>W.W. I</i>		20. INFORMATION <i>JOHNS HOPKINS HOSPITAL</i>	
21. ADDRESS		22. ADDRESS	

18. <i>163X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Lung, Rt.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 mo. (est.)</i>
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) DUE TO (B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <i>5-18-50</i>		19B. MAJOR FINDINGS OF OPERATION <i>Advanced &amp; inoperable Carcinoma, Rt. Lung.</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9-10</i> , 19 <i>50</i> , to <i>7-25</i> , 19 <i>50</i> , that I last saw the deceased alive on <i>7-25</i> , 19 <i>50</i> , and that death occurred at <i>1:15</i> A. M., from the causes and on the date stated above.					
23A. SIGNATURE <i>Andrew G. Monaw</i>		23B. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>		23C. DATE SIGNED <i>7-25-50</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>		24B. DATE <i>7/25/50</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Orleans</i>	
24D. LOCATION (City, town, or county) <i>New Orleans, Louisiana</i>		24E. DATE RECEIVED BY LOCAL REGISTRAR <i>JUL 25 1950</i>		24F. REGISTRAR'S SIGNATURE <i>Wm. Cook Jr.</i>	
24G. FUNERAL DIRECTOR <i>Wm. Cook Jr.</i>		24H. ADDRESS <i>1217 St. Paul Street</i>		24I. VS 150	

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William Wells

New Orleans  
1890

State of Louisiana

County of Orleans

Shirley C. Wells

Shirley C. Wells  
(nee)

2-18-20

Shirley C. Wells, nee

1890

1890

1890

1890

Shirley C. Wells

1890



**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6488

620  
50 6488  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCES VIRGINIA PIERCE</b>		2. DATE OF DEATH <b>July 24, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Windsor Nursing Home 3025 Windsor Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <span style="float:right"><u>15-03</u></span>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>2101 W. North Ave</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>June 7, 1870</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <b>80</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Emanuel Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Alice V. Triptlett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Ethel White-2101 W. North Ave.</b>		ADDRESS	

18. <b>447 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>Hypertension</b> (A) DUE TO	CAUSE OF DEATH  <b>Serility</b> (B) DUE TO <b>Generalized arteriosclerosis</b> (C) <b>none</b>	INTERVAL BETWEEN ONSET AND DEATH  <b>?</b>  <b>?</b>
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		
II  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>0</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 6/23, 1949 to 7/24, 1950, that I last saw the deceased alive on 7/14, 1950, and that death occurred at 9:55 A m., from the causes and on the date stated above.

23A. SIGNATURE <b>Lucretia Blum M.D.</b>	23B. ADDRESS <b>2310 Eutaw Place</b>	23C. DATE SIGNED <b>7/24/50</b>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7/26/50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Ward's Chapel</b>	24D. LOCATION (City, town, or county) (State) <b>Randallstown, Md.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>	REGISTRAR'S SIGNATURE <b>W. H. Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Wm. J. Schaner &amp; Sons, Balt. Md.</b>	ADDRESS
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MEDICAL CERTIFICATION

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6489  
Registered No. \_\_\_\_\_

640  
6489  
BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>PINKNEY-Whyte-CARROLL</b>			2. DATE OF DEATH <b>7-24-50</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>University Hosp</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY Hosp</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 28-01</b>		
C. Length of stay in Baltimore <b>26 yrs.</b>			D. STREET ADDRESS (If rural, give location) <b>5248 Reisterstown Rd.</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>W</b>	8. DATE OF BIRTH <b>Oct. 16, 1874</b>	9. AGE (In years last birthday) <b>75</b>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (rtd)</b>			11. BIRTHPLACE (State or foreign country) <b>Md</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>Park Board</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>CHARLES Carroll</b>			14. MOTHER'S MAIDEN NAME <b>Mary E.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>			16. SOCIAL SECURITY NO. _____		
17. INFORMANT <b>Mr. Charles H. Warner</b>			ADDRESS <b>Reisterstown, Md. - Nicodemus Rd.,</b>		

18. <b>581.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>choleemia</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Cirrhosis of Liver</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION <b>7-24-50</b>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>7-23</b> 19 <b>50</b> to <b>7-24</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>7-24</b> , 19 <b>50</b> , and that death occurred at <b>12:30 p.m.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Walter Glaser</b>		23B. ADDRESS <b>University Hosp</b>		23C. DATE SIGNED <b>7-24-50</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>7/26/50</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>	
				24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>		REGISTRAR'S SIGNATURE <b>Wm. J. Fickner</b>		25. FUNERAL DIRECTOR'S ADDRESS <b>Wm. J. Fickner &amp; Sons, Balto. Md.</b>	



315  
50 6490

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6490  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>VERNON STEVENS</b>		2. DATE OF DEATH <b>July 22, 1950</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>4-02</b>	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>740 Waesche St.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Single</b>	8. DATE OF BIRTH <b>Oct. 1895</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Sugar Refinery</b>	9. AGE (In years last birthday) <b>54</b>
11. BIRTHPLACE (State or foreign country) <b>Bellhaven, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Stevens</b>		14. MOTHER'S MAIDEN NAME <b>Laura La Cata</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.I</b>	
17. INFORMANT <b>Jesse Stevens</b>		ADDRESS <b>202 N. Fremont Ave.</b>	

18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Luetic Cardiovascular Disease with cardiac failure</b>		
DUE TO		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(B)</b>		
DUE TO		
<b>(C)</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE <i>William W. Williams</i>		23B. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR <input type="checkbox"/>		23C. DATE SIGNED <b>July 24, 1950</b>
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-27-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>		REGISTRAR'S SIGNATURE <i>William W. Williams</i>		25. FUNERAL DIRECTOR <i>Wm. H. Williams</i> ADDRESS <b>322</b>

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

50 6491  
Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **LILLIE LAKE**

2. DATE OF DEATH **July 24, 1950**

3. PLACE OF DEATH:  
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland**

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)  
**Baltimore 20-01**

**Franklin Square Hospital**

D. STREET ADDRESS (If rural, give location)  
**1827 W. Franklin Street**

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX **female**

6. COLOR OR RACE **colored**

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
**Married**

8. DATE OF BIRTH

**Aug. 1, 1881**

9. AGE (In years last birthday) **58**

If Under 1 Year Months: Days If Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired)  
**janitress**

10B. KIND OF BUSINESS OR INDUSTRY  
**City school**

11. BIRTHPLACE (State or foreign country)

**Washington, D.C.**

12. CITIZEN OF WHAT COUNTRY?  
**U.S.A.**

13. FATHER'S NAME

**Edward Shelton**

14. MOTHER'S MAIDEN NAME

**Barbara ?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

**No**

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

**Daniel Lake 1827 Franklin Street**

18. **203 X I**

**CAUSE OF DEATH**

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Multiple myeloma**

DUE TO

**ANTECEDENT CAUSES**

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an **autopsy** thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

23A. SIGNATURE

23B. CHIEF MEDICAL EXAMINER.....  
ASSISTANT MEDICAL EXAMINER.....  
MEDICAL INVESTIGATOR.....

23C. DATE SIGNED  
**July 24, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

EARLBOND CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

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50 6492BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 50 6492

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CLIFFORD BELL</b>			2. DATE OF DEATH <b>July 23, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Provident Hospital</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>		
C. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <b>2431 Madison Avenue</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>March 2, 1901</b>	9. AGE (In years last birthday) <b>49</b>	If Under 1 Year Months: Days If Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>night watchman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Construction Work</b>		
11. BIRTHPLACE (State or foreign country) <b>Va.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Isabella Holley</b>			ADDRESS <b>2431 Madison Avenue</b>		

18. <b>416 X</b> <b>012.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Rheumatic heart disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Tuberculosis of left hip and wrist</b> DUE TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH <b>Rheumatic heart disease</b> <b>Tuberculosis of left hip and wrist</b>	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE **Stanley H. Denecker** M.D.  
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐  
23C. DATE SIGNED **July 24, 1950**

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-26-1950</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial</b>	24D. LOCATION (City, town, or county) (State) <b>Arbutus Md.</b>
DATE RECEIVED BY LOCAL REGISTRAR <b>Jul 25 1950</b>	REGISTRAR'S SIGNATURE <b>Wilmington Williams, M.D.</b>	25. FUNERAL DIRECTOR <b>Mrs. Katie R. Williams</b>	ADDRESS <b>322</b>

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of medical examiner		12. Signature of health officer	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of family		18. Signature of friends		19. Signature of neighbors		20. Signature of community	
21. Signature of church		22. Signature of school		23. Signature of business		24. Signature of government	
25. Signature of other		26. Signature of other		27. Signature of other		28. Signature of other	
29. Signature of other		30. Signature of other		31. Signature of other		32. Signature of other	
33. Signature of other		34. Signature of other		35. Signature of other		36. Signature of other	
37. Signature of other		38. Signature of other		39. Signature of other		40. Signature of other	
41. Signature of other		42. Signature of other		43. Signature of other		44. Signature of other	
45. Signature of other		46. Signature of other		47. Signature of other		48. Signature of other	
49. Signature of other		50. Signature of other		51. Signature of other		52. Signature of other	
53. Signature of other		54. Signature of other		55. Signature of other		56. Signature of other	
57. Signature of other		58. Signature of other		59. Signature of other		60. Signature of other	
61. Signature of other		62. Signature of other		63. Signature of other		64. Signature of other	
65. Signature of other		66. Signature of other		67. Signature of other		68. Signature of other	
69. Signature of other		70. Signature of other		71. Signature of other		72. Signature of other	
73. Signature of other		74. Signature of other		75. Signature of other		76. Signature of other	
77. Signature of other		78. Signature of other		79. Signature of other		80. Signature of other	
81. Signature of other		82. Signature of other		83. Signature of other		84. Signature of other	
85. Signature of other		86. Signature of other		87. Signature of other		88. Signature of other	
89. Signature of other		90. Signature of other		91. Signature of other		92. Signature of other	
93. Signature of other		94. Signature of other		95. Signature of other		96. Signature of other	
97. Signature of other		98. Signature of other		99. Signature of other		100. Signature of other	

525

6493

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50

6493

Registered No.

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles A. Johnson

2. DATE  
OF  
DEATH

7-24-50

3. PLACE OF DEATH:

A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
A. STATE B. COUNTY before admission)B. FULL NAME OF (If not in hospital or institution, give street address or  
HOSPITAL OR location)  
INSTITUTION

Lutheran Hosp of Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1103 Elmridge Ave 29 5300

C. Length of stay in Baltimore

40

Yrs.  
Mos.  
Days

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

12-16-09

9. AGE (In years  
last birthday)

40

10 Under 1 Year  
Months: Days11 Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Chau. Elev.

10B. KIND OF BUSINESS OR  
INDUSTRY

B&amp;H Steel Co.

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

unk

14. MOTHER'S MAIDEN NAME

unk

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

WORLD WAR II

16. SOCIAL  
SECURITY NO.

216-05-2372

17. INFORMANT

Wife

ADDRESS

Same

18. 204, 3, 1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Irreversible Shock

DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Gastrointestinal Hemorrhage

DUE TO

(C) Acute leukemia

Approx. 19 mos.

## II

OTHER SIGNIFICANT CONDITIONS CON-  
TRIBUTING TO THE DEATH, BUT NOT RELATED  
TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT, SUICIDE,  
HOMICIDE (Specify)21B. PLACE OF INJURY (e. g., in or  
about home, farm, factory, street, office bldg., etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE ☐  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-18 1950 to 7-24, 1950 that I last saw the  
deceased alive on 7-24, 1950, and that death occurred at 052 m., from the causes and on the date stated above.

23A. SIGNATURE

John C. Hyle

M. D.

23B. ADDRESS

Lutheran Hosp of Md.

23C. DATE SIGNED

7-24-50

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

July 27, 1950

24C. NAME OF CEMETERY OR CREMATORY

LODENPARK

24D. LOCATION (City, town, or county)

BALTO. MD.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

J. J. Ambrose, Jr. 1328 Sulphur Spring Rd

VS 150

683 3A

74a

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6494**

**650**  
M M 105940  
BIRTH NO. **6494**

1. NAME OF DECEASED (Type or Print) <b>Charles Stanley Crane.</b>			2. DATE OF DEATH <b>July 22, 1950</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY		
B. FULL NAME OF (If not in hospital or institution, give street address or HOSPITAL OR INSTITUTE) <b>Baltimore City Hospitals</b> <b>4940 Eastern Ave.</b>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 12-05</b>		
c. Length of stay in Baltimore <b>Life</b>			D. STREET ADDRESS (If rural, give location) <b>1810 St. Paul St.</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Separated</b>	8. DATE OF BIRTH <b>April 24, 1884</b>		
			9. AGE (in years last birthday) <b>66</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William, J. Crane</b>			14. MOTHER'S MAIDEN NAME <b>Mary, Jane Kailer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT ADDRESS <b>Records B.C.H. 4940 Eastern Ave.</b>		

18. <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>CAUSE OF DEATH</b> <b>Carcinomatosis</b>	INTERVAL BETWEEN ONSET AND DEATH
<b>ANTECEDENT CAUSES</b>  <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>	

19A. DATE OF OPERATION <b>Feb. 13-1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Ca of Esophagus</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>11-3-46</b> , 19__, to <b>7-22-50</b> , 19__, that I last saw the deceased alive on <b>7-22-</b> , 19 <b>50</b> and that death occurred at <b>6:15 PM</b> from the causes and on the date stated above.					
23A. SIGNATURE <i>[Signature]</i>		23B. ADDRESS <b>4940 Eastern Ave</b>		23C. DATE SIGNED <b>7-24-50</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>July 26, 1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore City</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS <b>4611 Park Heights Ave.</b>	

**0558U 103**

**46a**

MEDICAL CERTIFICATION

1940, 1941, 1942

1943, 1944, 1945

1946, 1947, 1948, 1949, 1950

1951, 1952, 1953, 1954, 1955

1956, 1957, 1958, 1959, 1960

1961, 1962, 1963, 1964, 1965

1966, 1967, 1968, 1969, 1970

1971, 1972, 1973, 1974, 1975

1976, 1977, 1978, 1979, 1980

1981, 1982, 1983, 1984, 1985

1986, 1987, 1988, 1989, 1990

1991, 1992, 1993, 1994, 1995

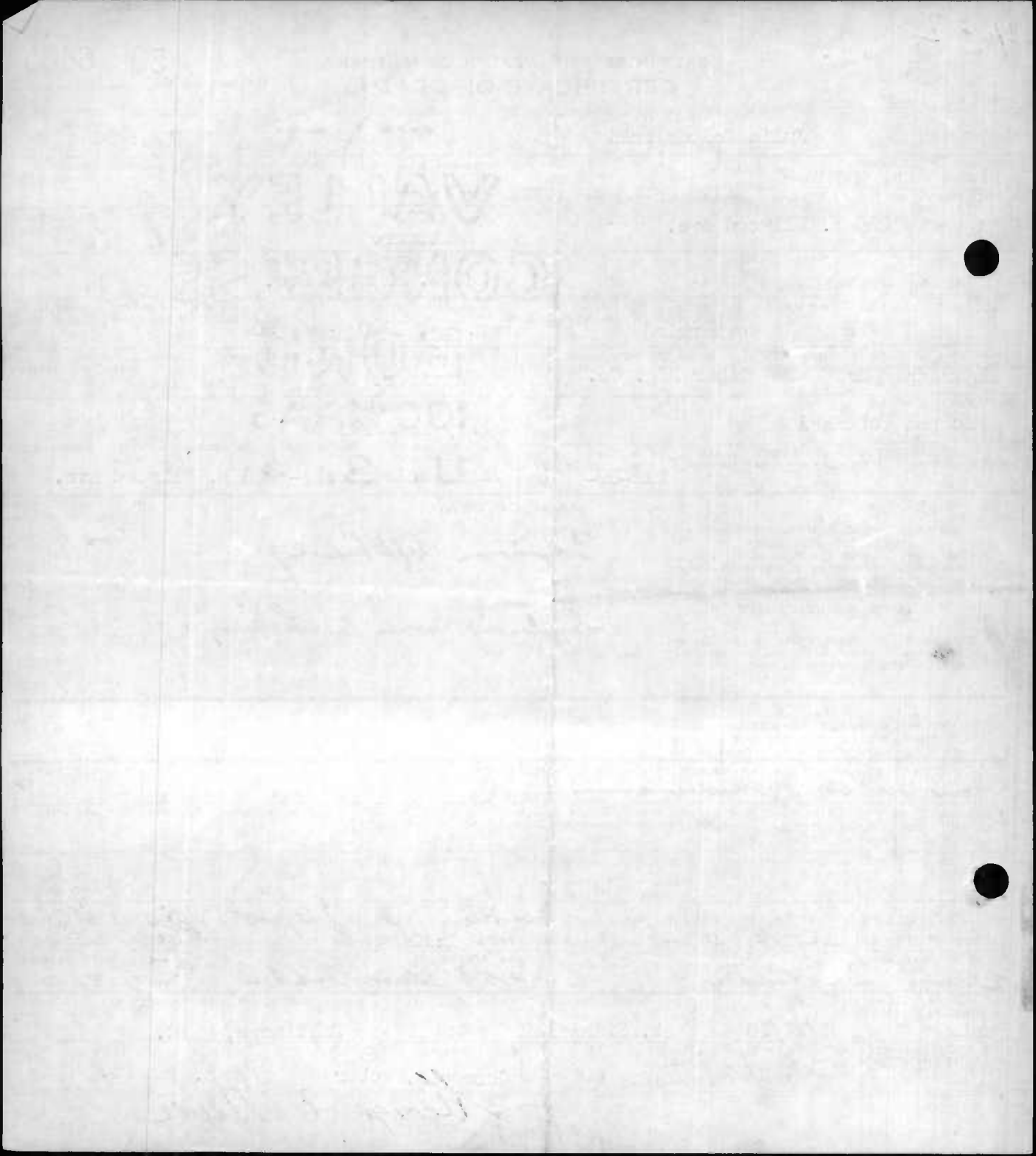
1996, 1997, 1998, 1999, 2000

2001, 2002, 2003, 2004, 2005

432  
0 6495BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH50 6495  
Registered No.

1. NAME OF DECEASED (Type or Print) <b>Julia Kolodzieski</b>		2. DATE OF DEATH <b>7/25/50</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>228 N. Ellwood Ave.</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>6-01</b>	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location) <b>228 N. Ellwood Ave.</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 15, 1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cigar Wrapper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Cigar Mfg. Co.</b>	9. AGE (in years last birthday) <b>50</b> If Under 1 Year: Months: Days If Under 24 Hours: Hours: Min.
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Micheal Cebulski</b>		14. MOTHER'S MAIDEN NAME <b>Mary Zawalski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-09-4826</b>	
17. INFORMANT <b>James Kolodzieski</b>		ADDRESS <b>228 N. Ellwood Ave..</b>	
18. <b>180 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>(A) Carcinoma Left Kidney</b> DUE TO <b>(B) Hydronephrosis Left Kidney</b> DUE TO <b>(C)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) Carcinoma Left Kidney</b> DUE TO <b>(B) Hydronephrosis Left Kidney</b> DUE TO <b>(C)</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>Trans +</b>
19A. DATE OF OPERATION <b>Jan 24 50</b>		19B. MAJOR FINDINGS OF OPERATION <b>Malignancy</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME (Month) (Day) (Year) (Hour) INJURY	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>March</b> , 19 <b>50</b> , to <b>July 25</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>July 14</b> , 19 <b>50</b> , and that death occurred at <b>1:10A</b> ., from the causes and on the date stated above.			
23A. SIGNATURE <b>George S. Lippert</b>		23B. ADDRESS <b>476 S. Calverton Park Ave</b>	
23C. DATE SIGNED <b>7/25/50</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>6/28/50</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>St..Stanislaus</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md..</b>	
25. FUNERAL DIRECTOR <b>George A. Weber</b>		ADDRESS <b>705 S. Ann St..</b>	

6904A George A Weber 52a



216  
6496

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6496  
Registered No.

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
		Kaspar, Marie		July 23, 1950	
3. PLACE OF DEATH:		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
A. Baltimore City, Maryland		A. STATE Md.			
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
St. Joseph's		Baltimore			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)			
28 years		2819 E. Madison St.			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Year Months: Days
F.	W.	Married	October 1, 1902	47	11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk & Wife.		Own Home & Grocery Store		Czechoslovakia	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
unknown		unknown		U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or ookoowo)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				John C. Kaspar, 2819 E. Madison St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES		(A) Carcinoma of head of the Pancreas			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) Carcinoma of Stomach			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 13, 1950 to July 23, 1950, that I last saw the deceased alive on July 23, 1950 and that death occurred at 4:15 p.m., from the causes and on the date stated above.					
23A. SIGNATURE		23B. ADDRESS		23C. DATE SIGNED	
B. B. Z. Z. Z.		1100 N. Caroline St.		July 23, 1950	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		July 26, 1950		Oak Hill Cemetery	
DATE RECEIVED BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR ADDRESS	
JUL 25 1950		Huntington Williams, M.D.		Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.	

MEDICAL CERTIFICATION





**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. \_\_\_\_\_

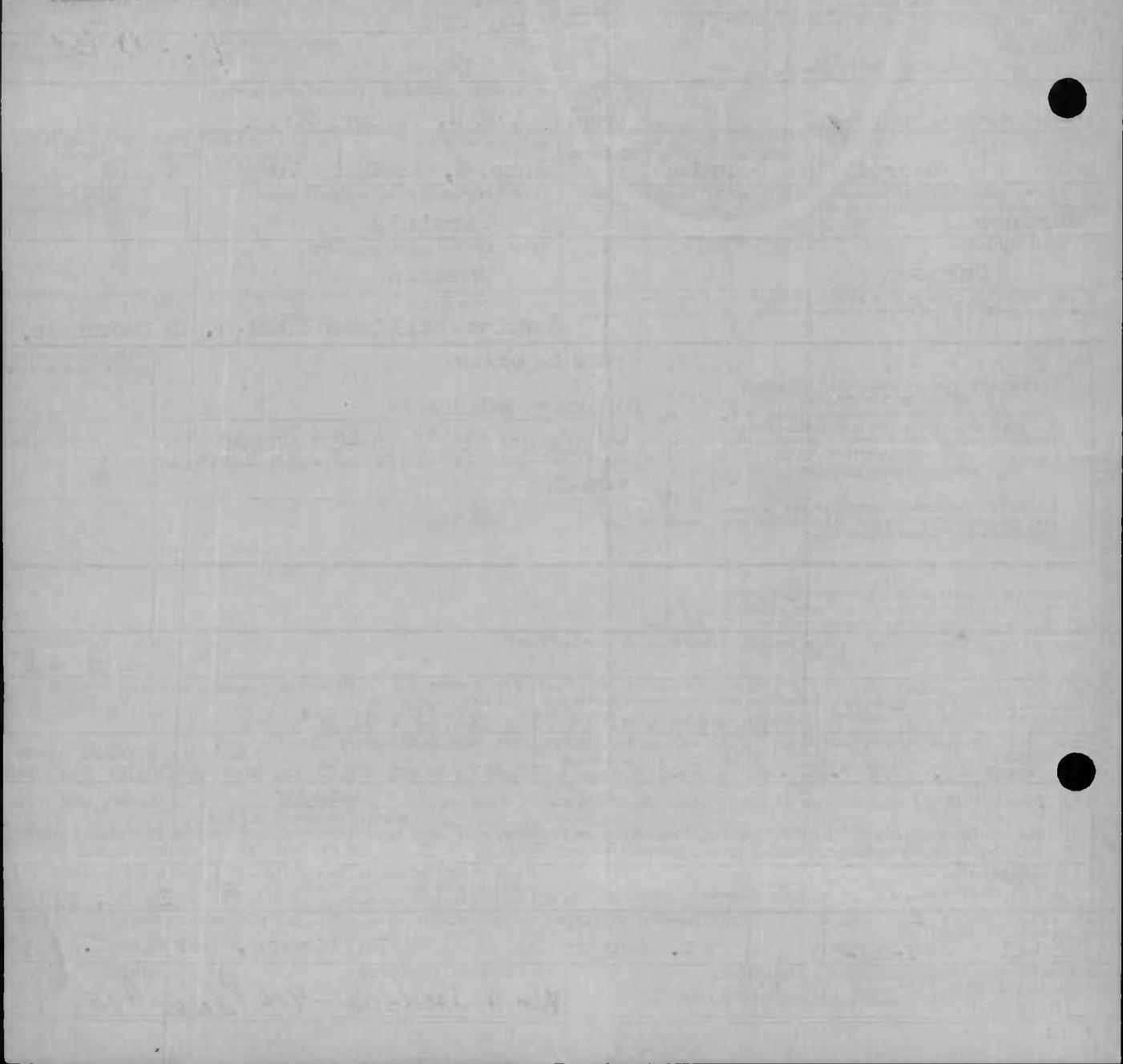
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>JUSTICE STITH</b>		2. DATE OF DEATH <b>July 23, 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY _____			
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>Mercy Hospital</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>			
C. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) <b>1029 N. Calhoun Street</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>June 4, 1880</b>	9. AGE (In years last birthday) <b>70</b>	10. Under 1 Year Months: <b>1</b> Days: <b>19</b> 11. Under 24 Hours Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>		10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT ADDRESS <b>Louise Williams 1029 N. Calhoun St.</b>	

18. <b>E 902.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary embolus</b> DUE TO <b>thrombo phlebitis of legs due to compression fracture of 10th thoracic vertebra</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. _____		

19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>house under construction</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>on 5417 St. Alban's Way</b>			
21D. TIME (Month) (Day) (Year) (Hour) <b>July 13, 1950 7.30a. m.</b>	21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>Fell to ground when platform on which he was standing slipped</b>			
22. I certify that I took charge of the remains described above, held an <b>autopsy</b> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
23A. SIGNATURE <i>Stanley B. Dunscheer</i>		23B. CHIEF MEDICAL EXAMINER..... <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER..... <input checked="" type="checkbox"/> MEDICAL INVESTIGATOR..... <input type="checkbox"/>		23C. DATE SIGNED <b>July 24, 1950</b>	

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>7-28-50</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>
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DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 25 1950</b>	REGISTRAR'S SIGNATURE <i>Wm. A. Jackson</i>	25. FUNERAL DIRECTOR ADDRESS <b>Wm. A. JACKSON - 916 PENN. AVE.</b>
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460  
6498

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

50 6498  
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print)		FLORENCE (FLORRIE) E. WHEELER		2. DATE OF DEATH July 25, 1950	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md.			
B. FULL NAME OF HOSPITAL OR INSTITUTION 1909 Walbrook Ave.		C. CITY OR TOWN (If outside corporate limits, write full name, and give township) Baltimore			
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location) 1909 Walbrook Ave.			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH May 15, 1875		9. AGE (in years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) floorlady		10B. KIND OF BUSINESS OR INDUSTRY Wholesale Clothing		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Jacob Wheeler		14. MOTHER'S MAIDEN NAME Jennie Staines			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 214-01-5558		17. INFORMANT ADDRESS Mrs. Carrie Smoyer 1909 Walbrook Ave.	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 155X I Sarcoma of Liver (with metastases)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.
DUE TO (A)		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Ch. myocarditis		1949
DUE TO (B)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING IT.		

19A. DATE OF OPERATION Mar. 31, 1950		19B. MAJOR FINDINGS OF OPERATION Malignant Sarcoma		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 20, 1950, to July 25, 1950, that I last saw the deceased alive on July 24, 1950, and that death occurred at 6:54 a.m., from the causes and on the date stated above.					
23A. SIGNATURE Paul Brown		23B. ADDRESS M. O. 1663 W. North St.		23C. DATE SIGNED 7-25-50	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 7/28/50		24C. NAME OF CEMETERY OR CREMATORY Providence Cem.	
24D. LOCATION (City, town, or county) (State) Gamber, Md.		25. FUNERAL DIRECTOR Thos. J. Cichner & Sons			
DATE RECEIVED BY LOCAL REGISTRAR JUL 25 1950		REGISTRAR'S SIGNATURE Huntington Williams, Jr.		ADDRESS Baltimore, Md.	

VALLEY  
CONCRETE  
CORPORATION

17  
1941

1941

1941

1941

1941

**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. **50 6499**

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANNA PETRONELLA WASSELL</b>		2. DATE OF DEATH <b>July 23 1950</b>	
3. PLACE OF DEATH: A. Baltimore City, Maryland <b>863 1/2 W. Lombard St</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Ind</b> B. COUNTY <b>Balto.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Balto. 18-23</b>	
C. Length of stay in Baltimore <b>49 yrs</b>		D. STREET ADDRESS (If rural, give location) <b>863 1/2 W Lombard St</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>July 25-1876</b>
9. AGE (in years last birthday) <b>73</b>		10. Under 1 Year: Months: Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. FATHER'S NAME <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		14. SOCIAL SECURITY NO. <b>—</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Frank J. Wassell</b>		ADDRESS <b>863 1/2 W Lombard St</b>	

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>155-X I</b>		CAUSE OF DEATH <b>Carcinoma of Hepatic Duct.</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO	
(B) DUE TO			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			

19A. DATE OF OPERATION <b>July 20, 1950</b>		19B. MAJOR FINDINGS OF OPERATION <b>Carcinoma of Hepatic Duct.</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 1946</b> to <b>July 23, 1950</b> that I last saw the deceased alive on <b>July 20, 1950</b> and that death occurred at <b>1255</b> m., from the causes and on the date stated above.					
23A. SIGNATURE <b>J. Edwin Muller</b>		23B. ADDRESS <b>2 W Reed St</b>		23C. DATE SIGNED <b>23 July 50</b>	

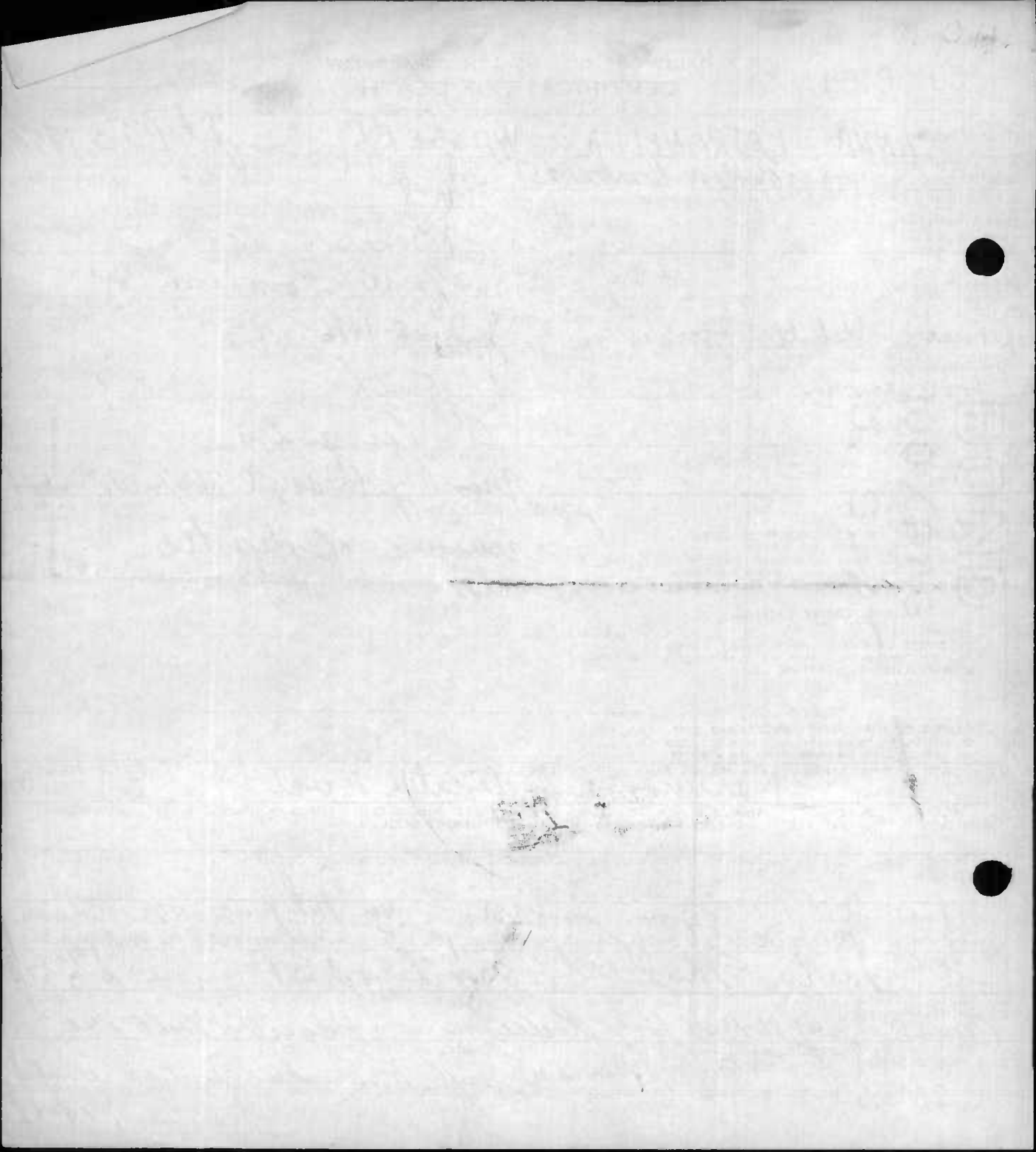
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>July 26-1950</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Belair Rd Balt Md</b>	
DATE RECEIVED BY LOCAL REGISTRAR <b>JUL 26 1950</b>		REGISTRAR'S SIGNATURE <b>William W. Williams, Jr.</b>		25 FUNERAL DIRECTOR <b>Joseph Kasunakao</b>		ADDRESS <b>602 Wash.</b>	

MEDICAL CERTIFICATION

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**BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH**

Registered No. 50 6500

BIRTH NO. 425  
50 6500

1. NAME OF DECEASED (Type or Print) <u>Mrs. Flora W. Wilson</u>			2. DATE OF DEATH <u>July 25, 1950</u>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE <u>University Hosp.</u>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u>		
c. Length of stay in Baltimore			D. STREET ADDRESS (If rural, give location) <u>6410 Pinehurst Rd. 5200</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 31, 1897</u>		9. AGE (In years last birthday) <u>52</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>
13. FATHER'S NAME <u>William H. Winkelman</u>			14. MOTHER'S MAIDEN NAME <u>Anna S. Aull</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Mr. Donald Wilson 6410 Pinehurst Rd.</u>		

18. <u>170X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <u>Generalized Carcinomatosis of breast and ovaries</u> ANTECEDENT CAUSES  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.	CAUSE OF DEATH (A) <u>Generalized Carcinomatosis of breast and ovaries</u> DUE TO (B) DUE TO (C)	INTERVAL BETWEEN ONSET AND DEATH
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19A. DATE OF OPERATION <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME (Month) (Day) (Year) (Hour) INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7-8, 1950, to 7-25, 1950, that I last saw the deceased alive on 7-25, 1950, and that death occurred at 11:30 Am., from the causes and on the date stated above.

23A. SIGNATURE <u>R.C. Spaulding Jr.</u>	M. O. <u>University Hosp.</u>	23B. ADDRESS <u>University Hosp.</u>	23C. DATE SIGNED <u>7-25-50</u>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>7/28/50</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>	24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
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DATE RECEIVED BY LOCAL REGISTRAR <u>JUL 26 1950</u>	REGISTRAR'S SIGNATURE <u>Wm. J. Dickener &amp; Sons</u>	25. FUNERAL DIRECTOR <u>Wm. J. Dickener &amp; Sons</u>	ADDRESS <u>Balto Md.</u>
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